2015

Molina Healthcare of Washington, Inc.
Agreement and Individual Policy

Molina Marketplace Bronze

Washington

21540 30th Dr. SE Suite 400, Bothell, WA 98021

IF YOU ARE A QUALIFYING AMERICAN INDIAN OR ALASKAN NATIVE. THAT HAS A COST SHARING REQUIREMENT IN YOUR PLAN THEN YOU WILL BE RESPONSIBLE FOR COST SHARING UNDER THIS PLAN FOR ANY COVERED SERVICES NOT PROVIDED BY A PARTICIPATING TRIBAL HEALTH PROVIDER. TRIBAL HEALTH PROVIDERS INCLUDE THE INDIAN HEALTH SERVICE, AN INDIAN TRIBE, TRIBAL ORGANIZATION, OR URBAN INDIAN ORGANIZATION.

MolinaHealthcare.com/Marketplace

MOLINA® HEALTHCARE

Your Extended Family.

MHW01012015

MOLINA HEALTHCARE OF WASHINGTON, INC.
SCHEDULE OF BENEFITS
MOLINA BRONZE PLAN

THE SCHEDULE BELOW IS INTENDED TO BE USED TO HELP YOU DETERMINE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE MOLINA HEALTHCARE OF WASHINGTON, INC. AGREEMENT AND INDIVIDUAL POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF BENEFITS AND LIMITATIONS.

Deductible Type	**You Pay**
Combined Medical and Prescription Deductible (Deductible waived for Preventative and first three Office visits and Generic Drugs)	
Individual	$4,500
Family (2 or more Members)	$9,000
Annual Out of Pocket Maximum	**You Pay**
Individual	$6,600
Family (2 or more Members)	$13,200
Emergency Room and Urgent Care Services	**You Pay**
Emergency Room*	$300 Copayment per visit
Urgent Care	$75 Copayment per visit

*This cost does not apply if admitted directly to the hospital for inpatient services (Refer to Inpatient Hospital/Facility Services, for applicable Cost Sharing to You)

Outpatient Professional Services**	**You Pay**
Office Visits	
Preventive Care (Includes prenatal and first postpartum exam)	No Charge
Primary Care	$25 Copayment per visit
Specialty Care	$75 Copayment per visit
Other Practitioner Care	$75 Copayment per visit
Habilitative Services	40% Coinsurance
Rehabilitative Services • Speech, physical and occupational therapy, combined limit of 25 visits per calendar year • Spinal manipulations limited to 10 per calendar year • Acupuncture services limited to 12 per calendar year	40% Coinsurance
Mental Health Services (Includes mental health and behavioral health medically necessary treatments and eating disorder treatments for DSM classified disorders)	$25 Copayment per visit
Substance Abuse Disorder Services (Includes chemical dependency detoxification, subject to medical necessity criteria, and acupuncture treatments)	$25 Copayment per visit

Nutritional Counseling		$25	Copayment per visit
Phenylketonuria (PKU)			
Preventive Care Screening for Children		No Charge	
Testing and Treatment of PKU		$25	Copayment
Diabetes Management			
Preventive Care for Children and Adults		No Charge	
Diabetes Care other than Preventive Care		$25	Copayment
Cancer Chemotherapy		40%	Coinsurance
Pediatric Vision Services (for Members under Age 19 only)			
Vision Exam (screening and exam, limited to 1 each calendar year)		No Charge	
Prescription Glasses		No Charge	
Frames	• Limited to one pair of frames every 12 months • Limited to a selection of covered frames		
Lenses	Limited to one pair of prescription lenses every 12 months • Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses • All lenses include scratch resistant coating, and ultraviolet protection (UV)	No Charge	
Prescription Contact Lenses Limited to one year supply every 12 months, in lieu of prescription glasses as Medically necessary for specified medical conditions		No charge	
Low Vision Optical Devices and Services (subject to limitations and Prior Authorization applies)		No Charge	
Dental & Orthodontic Services			
Temporomandibular Joint Syndrome (Medically Necessary Non-surgical Treatment)		40%	Coinsurance
Family Planning (Family planning services, including those of all FDA approved birth control supplies and services)		No Charge	

****General medical care provided by a Participating Provider**

Outpatient Hospital / Facility Services	**You Pay**	
Outpatient Surgery		
Professional	40%	Coinsurance

Facility	40%	Coinsurance
Specialized Scanning Services		
CT Scan	40%	Coinsurance
PET Scan	40%	Coinsurance
MRI	40%	Coinsurance
Cancer Chemotherapy	40%	Coinsurance
Radiology Services	$75	Copayment
Dental Services (Radiation therapy of cancer or neoplastic diseases of the head or neck)	$75	Copayment
Laboratory Services	$30	Copayment
Mental Health		
Outpatient Intensive Psychiatric Treatment Programs	40%	Coinsurance
Dental & Orthodontic Services		
Dental Anesthesia (Medically Necessary)	$75	Copayment

Inpatient Hospital / Facility Services		**You Pay**
Medical / Surgical		
Professional	40%	Coinsurance
Facility	40%	Coinsurance
Cancer Chemotherapy	40%	Coinsurance
Dental & Orthodontic Services		
Dental Anesthesia (Resulting from an underlying medical condition)	40%	Coinsurance
Dental Trauma (Medically Necessary oral surgery due to injury and trauma)	40%	Coinsurance
Cleft Palate (Medically Necessary reconstructive surgery)	40%	Coinsurance
Temporomandibular Joint Syndrome (Medically necessary surgical and arthroscopic treatment)	40%	Coinsurance
Maternity Care (Professional and Facility Services)	40%	Coinsurance
Rehabilitative Services **30** day limit per calendar year	40%	Coinsurance
Mental Health (Inpatient Psychiatric Hospitalization)	40%	Coinsurance
Substance Abuse Disorders		
Inpatient Detoxification	40%	Coinsurance
Transitional Residential Recovery Services	40%	Coinsurance
Transplant Services	40%	Coinsurance
Skilled Nursing Facility (limited to 60 days per calendar year)	40%	Coinsurance

Long-Term Care Facility Following Hospitalization	40%	Coinsurance
Hospice Care	No Charge	

Prescription Drug Coverage		**You Pay**
Formulary Generic Drugs	$16	Copayment
Formulary Preferred Brand Name Drugs	$65	Copayment
Formulary Non-Preferred Brand Name Drugs	40%	Coinsurance
Specialty Drugs (Oral and Injectable Drugs)	40%	Coinsurance

Please refer to Page 45-48 for a description of Prescription Drug benefits.

Ancillary Services		**You Pay**
Durable Medical Equipment	40%	Coinsurance
Home Healthcare (limited to 130 visits)	$75	Copayment per visit
Emergency Medical Transportation (Ambulance)	$100	Copayment
Other Services		**You Pay**
Dialysis Services	$75	Copayment

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This **Molina Healthcare of Washington, Inc. Agreement and Individual Policy** (also called the "**Policy**" or "**Agreement**") is issued by Molina Healthcare of Washington, Inc. ("**Molina Healthcare**", "**Molina**", "**We**", or "**Our**"), to the Subscriber or Member whose identification cards are issued with this Agreement. In consideration of statements made in any required application and timely payment of Premiums, Molina agrees to provide the Benefits and Coverage as described in this Agreement.

This Agreement, including any attached amendments, and the application(s) submitted to the Health Benefit Exchange to obtain coverage under this Agreement which are incorporated into this Agreement by reference, constitute the legally binding contract between Molina Healthcare and the Subscriber.

WELCOME

Welcome to Molina!

Here at Molina, We'll help You meet Your medical needs. If You are a Molina Member, this Policy tells You what services You can get.

If You are thinking about becoming a Molina Member, this Policy can help You make a decision. You may call Molina and request information about Molina's health plans and available disclosure information.

Molina Healthcare is a Washington registered Health Maintenance Organization.

If You have any questions about anything in this Policy, about Molina Healthcare, or if You need this information in another language, large print, Braille, or audio, You may call or write to us at:

Molina Healthcare of Washington, Inc.
Customer Support Center
P.O. Box 4004
Bothell, WA 90841

www.molinahealthcare.com
(888)858-3492

If You are deaf or hard of hearing You may contact us through the National Relay Service by dialing 711.

INTRODUCTION

Thank You for Choosing Molina as Your Health Plan.

This document is called Your "Molina Healthcare of Washington, Inc. Agreement and Individual Policy" (Your "**Agreement**" or "**Policy**"). The Policy tells You how You can get services through Molina. It also sets out the terms and conditions of coverage under this Agreement, Your rights and responsibilities as a Molina Member and how to contact Molina. Please read this Policy completely and carefully and keep it in a safe place where You can get to it quickly. If You have special health care needs, carefully read the sections that apply to You.

Molina is Here to Serve You.

Call Molina if You have questions or concerns. Our helpful and friendly staff will be happy to help You. We can help You choose a doctor, make an appointment. We can also listen and respond to Your questions or complaints. You can ask us about Your benefits with Molina. We can help with concerns about Your doctor or any other Molina Healthcare services.

Call us toll-free at 1 (888) 858-3492 between 8:00 a.m. to 5:00 p.m. PT Monday through Friday. If You are deaf or hard of hearing, You may contact us by dialing 711 for the National Relay Service.

Call us if You move from the address You had when You enrolled with Molina. Let us know if you change phone numbers. Please contact Our Customer Support Center to update that information.

Sharing Your updated address and phone number with Molina. This will help us get information to You. We can send You newsletters and other materials. We can reach You by phone if We need to contact You.

DEFINITIONS

Some of the words used in this Policy do not have their usual meaning. Molina uses these words in a special way. When We use a word with a special meaning in only one section of this Policy, We explain what it means in that section. Words with special meaning used in any section of this Policy are explained in this "Definitions" section.

"**Adverse Benefit Determination**" means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of an Member's or applicant's eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

"**Affordable Care Act**" means the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010, together with the federal regulations implementing this law and binding regulatory guidance issued by federal regulators.

"**Annual Out-of-Pocket Maximum**"

For Individuals - is the total amount of Cost Sharing You, as an individual Member, will have to pay for Covered Services in a calendar year. The Cost Sharing and individual Annual Out-of-Pocket Maximum amounts applicable to Your Policy are specified in the Molina Healthcare of Washington, Inc. Schedule of Benefits. For this Policy, Cost Sharing includes payments You make towards any Deductibles, Copayments or Coinsurance. Once Your total Cost Sharing in a calendar year reaches the specified individual Annual Out-of-Pocket Maximum amount, we will pay 100% of the charges for Covered Services for the remainder of the calendar year. Amounts that You pay for services that are not Covered Services under this Policy will not count towards the individual Annual Out-of-Pocket Maximum.

For Family (2 or more Members) – is the total amount of Cost Sharing that at least two or more Members of a family will have to pay for Covered Services in a calendar year. The Cost Sharing and family Annual Out-of-Pocket Maximum amounts applicable to Your Policy are specified in the Molina Healthcare of Washington, Inc. Schedule of Benefits. For this Policy, Cost Sharing includes payments You make towards any Deductibles, Copayments or Coinsurance. Once the total Cost Sharing made by at least two or more Members of a family reaches the specified Annual Out-of-Pocket Maximum amount, we will pay 100% of the charges for Covered Services for all enrolled family Members for the remainder of the calendar year. Amounts that You pay for services that are not Covered Services under this Policy will not count towards the family Annual Out-of-Pocket Maximum.

"**Authorization or Authorized**" means a decision to approve specialty or other Medically Necessary care for a Member by the Member's PCP, medical group or Molina. An Authorization is usually called an "approval."

"**Benefits and Coverage**" (also referred to as "**Covered Services**") means the healthcare services that You are entitled to receive from Molina under this Agreement.

"Child-Only Coverage" means coverage under this Policy that is obtained by a responsible adult to provide benefit coverage only to a child under the age of 21.

"**Coinsurance**" is a percentage of the charges for Covered Services You must pay when You receive Covered Services. The Coinsurance amount is calculated as a percentage of the rates that Molina has negotiated with the Participating Provider. Coinsurances are listed in the Molina of Washington, Inc. Schedule of Benefits. Some Covered Services do not have Coinsurance, and may apply a Deductible or Copayment.

"**Copayment**" is a specific dollar amount You must pay when You receive Covered Services. Copayments are listed in the Molina Healthcare of Washington, Inc. Schedule of Benefits. Some Covered Services do not have a Copayment, and may apply a Deductible or Coinsurance.

"**Cost Sharing**" is the Deductible, Copayment, or Coinsurance that You must pay for Covered Services under this Agreement. The Cost Sharing amount You will be required to pay for each type of Covered Service is listed in the Molina Healthcare of Washington, Inc. Schedule of Benefits at the beginning of this Policy.

"**Deductible**" is the amount You must pay in a calendar year for Covered Services You receive before Molina will cover those services at the applicable Copayment or Coinsurance. The amount that You pay towards Your Deductible is based on the rates that Molina has negotiated with the Participating Provider. Deductibles are listed in the Molina Healthcare of Washington, Inc. Schedule of Benefits. Please refer to the Molina Healthcare of Washington, Inc. Schedule of Benefits to see what Covered Services are subject to the Deductible and the Deductible amount. Your product may have separate Deductible amounts for specified Covered Services. If this is the case, amounts paid towards one type of Deductible cannot be used to satisfy a different type of Deductible. When Molina covers services at "no charge" subject to the Deductible and You have not met Your Deductible amount, You must pay the charges for the services. When preventive services covered by this Agreement are included in the Essential Health Benefits, You will not pay any Deductible or other Cost Sharing towards such preventive services. There may be a Deductible listed for an individual Member and a Deductible for an entire family. If You are a Member in a family of two or more Members, You will meet the Deductible either:

(i) when You meet the Deductible for the individual Member; or
(ii) when Your family meets the Deductible for the family.

For example, if You reach the Deductible for the individual Member, You will pay the applicable Copayment or Coinsurance for Covered Services for the rest of the calendar year, but every other Member in Your family must continue to pay towards the Deductible until Your family meets the family Deductible

"**Dependent**" means a Member who meets the eligibility requirements as a Dependent, as described in this Policy.

"**Drug Formulary**" is Molina's list of approved drugs that doctors can order for You.

"**Durable Medical Equipment**" is medical equipment that serves a repeated medical purpose and

is intended for repeated use. It is generally not useful to You in the absence of illness or injury and does not include accessories primarily for Your comfort or convenience. Examples include, without limitation: oxygen equipment, blood glucose monitors, apnea monitors, nebulizer machines, insulin pumps, wheelchairs and crutches.

"**Emergency**" or "**Emergency Medical Condition**" means the acute onset of a medical condition or a psychiatric condition that has acute symptoms of sufficient severity (including severe pain), such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in:

- Placing the health of the Member, or if the Member is pregnant, her health or the health of her unborn child, in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

"**Emergency Services**" mean health care services needed to observe, evaluate, stabilize or treat an Emergency Medical Condition.

"**Essential Health Benefits**" or "**EHB**" means a standardized set of essential health benefits that are required to be offered by Molina to You and/or Your Dependents, as determined by the Affordable Care Act. Essential Health Benefits covers at least the following 10 categories of benefits:

- Ambulatory patient care
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including dental***** and vision care for Members under the age of 19

*****Pediatric dental services will be separately provided through a stand-alone dental plan that is certified by the Health Benefit Exchange.

"**Experimental or Investigational**" means any medical service including procedures, medications, facilities, and devices that Molina has determined have not been demonstrated as safe or effective compared with conventional medical services. In determining whether services are experimental or investigational, Molina will consider whether the services are in general use in the medical community in the State of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious.

"**Health Benefit Exchange**" means a governmental agency or non-profit entity that meets the applicable standards of the Affordable Care Act and helps residents of the State of Washington buy qualified health plan coverage from insurance companies or health plans such as Molina. The Health Benefit Exchange may be run as a state-based marketplace, a federally-facilitated marketplace or a partnership marketplace. For the purposes of this Agreement, the term refers to the Health Benefit Exchange operating in the State of Washington however it may be organized and run.

"**Medically Necessary**" or "**Medical Necessity**" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. Those services must be deemed by Molina to be:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

"**Molina Healthcare of Washington, Inc. ("Molina Healthcare" or "Molina")**" means the corporation registered in Washington as a Health Maintenance Organization, and contracted with the Health Benefit Exchange. This Policy sometimes refers to Molina as "We" or "Our".

"**Molina Healthcare of Washington, Inc. Agreement and Individual Policy"** means this booklet, which has information about Your benefits. It is also called the "Policy" or "Agreement".

"**Member**" means an individual who is eligible and enrolled under this Agreement, and for whom We have received applicable Premiums. The term includes a Dependent and a Subscriber, unless the Subscriber is a responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under this Agreement on behalf of a child under age 21, in which case the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member, and will act as the legal representative of Member under this Product but will not be a Member. This Policy sometimes refers to a Member as "You" or "Your".

"**Non-Participating Provider"** refers to those physicians, hospitals, and other providers that have not entered into contracts to provide Covered Services to Members.

"**Other Practitioner**" refers to individual Participating Providers who provide Covered Services to Members within the scope of their license, but are not Primary Care Physicians or Specialist Physicians.

"**Participating Provider**" refers to those healthcare providers, including hospitals and physicians, regulated under Washington law to practice health or health-related services that are practicing within the scope of their licenses that have entered into contracts to provide Covered Services to Members through this Policy offered and sold through the Health Benefit Exchange.

"**Premiums**" mean periodic membership charges paid by or on behalf of each Member. Premiums are in addition to Cost Sharing.

"**Primary Care Doctor**" (also a "**Primary Care Physician**" and "**Personal Doctor**") is the doctor who takes care of Your health care needs. Your Primary Care Doctor has Your medical

history. Your Primary Care Doctor makes sure You get needed health care services. A Primary Care Doctor may refer You to Specialist Physicians or other services. A Primary Care Doctor includes, but is not limited to, the following types of doctors:

- Family or general practice physicians who usually can see the whole family.
- Internal medicine doctors, who usually only see adults and children 14 years or older.
- Pediatricians, who see children from newborn to age 18 or 21.
- Obstetricians and gynecologists (OB/GYNs).

"**Primary Care Provider**" or "**PCP**" means:

- A Primary Care Doctor, or
- Individual practice association (IPA), or
- Group of licensed doctors which provides primary care services through the Primary Care Doctor.

"**Referral**" means the process by which the Member's Primary Care Doctor directs the Member to seek and obtain Covered Services from other providers.

"**Service Area**" means the geographic area in Washington where Molina has been authorized by the Washington State Office of the Insurance Commissioner to market individual products sold through the Health Benefit Exchange, enroll Members obtaining coverage through the Health Benefit Exchange and provide benefits through approved individual health plans sold through the Health Benefit Exchange. The Service Area consists of Chelan, Douglas, Grant, King, Okanogan, Pierce and Spokane Counties.

"**Specialist Physician**" means any licensed, board-certified, or board-eligible physician who practices a specialty and who has entered into a contract to deliver Covered Services to Members.

"**Spouse**" means the Subscriber's legal husband or wife. For purposes of this Policy, the term "**Spouse**" includes the Subscriber's same-sex spouse if the Subscriber and spouse are a couple who meet all of the requirements of Washington law, or the Subscriber's registered domestic partner who meets all the requirements of Washington law.

"**Subscriber**" means either i) an individual who is a resident of Washington, satisfies the eligibility requirements of this Agreement, is enrolled and accepted by Molina as the Subscriber, and has maintained membership with Molina in accord with the terms of this Agreement; or ii) a responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under this Agreement on behalf of a child under age 21, in which case the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member, and will act as the legal representative of Member under this Agreement.

"Substance Abuse Disorder" has the meaning consistent with definitions in Title 48 RCW for chemical dependency relating to an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

"**Urgent Care Services**" mean those health care services needed to prevent the serious deterioration of one's health from an unforeseen medical condition or injury.

"**You"** or **"Your"** means either the Member or Subscriber, as the context requires, throughout the Policy. By way of example only, where Subscriber will act as the legal representative of Member under this Agreement, "You" or "Your" shall mean Subscriber.

ELIGIBILITY AND ENROLLMENT

When will My Molina Membership Begin?
Your coverage begins on the Effective Date. The Effective Date is the date You meet all enrollment and Premium pre-payment requirements and are accepted by the Health Benefit Exchange.

If You fail to enroll during an open enrollment period, You have special enrollment rights based upon current state and federal law, You may be able to enroll during a special enrollment period for which You are determined eligible in accordance with the special enrollment procedures established by the Health Benefit Exchange. In such case, the Effective Date of coverage will be as determined by the Health Benefit Exchange. Without limiting the above, the Health Benefit Exchange will provide special monthly enrollment periods for eligible American Indians or Alaska Natives.

The Effective Date for coverage of new Dependents is described below in the section titled "Adding New Dependents."

Who is Eligible?
To enroll and continue enrollment, Member must meet all of the eligibility requirements established by the Health Benefit Exchange. Check the Health Benefit Exchange website for eligibility criteria. For Child-Only Coverage, the Member must be under the age of 21, and the Subscriber must be a responsible adult (parent or legal guardian) applying on behalf of the child. Molina requires Members to live or work in Molina's Service Area for this Policy. If You have lost Your eligibility, as described in the section titled "When Will My Molina Membership End? (Termination of Benefits and Coverage)", You may not be permitted to re-enroll.

Dependents: Subscribers who enroll in this Policy during the open enrollment period established by the Health Benefit Exchange may also apply to enroll eligible Dependents who satisfy the eligibility requirements. Molina requires Dependents to live or work in Molina's Service Area for this Policy. The following types of family members are considered Dependents:

- Spouse
- Children: The Subscriber's children or his or her Spouse's children (including legally adopted children and stepchildren). Each child is eligible to apply for enrollment as a Dependent until the age of 26 (the limiting age).
- Subscriber's grandchildren generally do not qualify as Dependents of the Subscriber unless added as a newborn child of a covered Dependent child or of a Member covered by Child-Only Coverage under this Agreement. Coverage for children of a covered Dependent child or of a Member under a Child-Only Coverage will end when the covered Dependent child or Member under a Child-Only Coverage is no longer eligible under this Agreement.

Age Limit for Children (Disabled Children): Children who reach age 26 are eligible to continue enrollment as a Dependent for coverage if all of the following conditions apply:

- The child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and
- The child is chiefly dependent upon the Subscriber for support and maintenance.

Molina or the Health Benefit Exchange will provide the Subscriber with notice at least 90 days prior to the date the Subscriber's enrolled child reaches the limiting age at which the Dependent child's coverage will terminate. The Subscriber must provide Molina or the Health Benefit Exchange with proof of his or her child's incapacity and dependency within 60 days of the date of receiving such notice in order to continue coverage for a disabled child past the limiting age.

The Subscriber must provide the proof of incapacity and dependency at no cost to Molina.

A disabled child may remain covered by Molina as a Dependent for as long as he or she remains incapacitated and continues to meet the eligibility criteria described above.

Adding New Dependents: To enroll a Dependent who first becomes eligible to enroll after the Subscriber or Member (in the case of Child-Only coverage) is enrolled (such as a new Spouse, a newborn child or a newly adopted child), You must contact the Health Benefit Exchange and submit any required application(s), forms and requested information for the Dependent. Requests to enroll a new Dependent must be submitted to the Health Benefit Exchange within 60 days from the date the Dependent became eligible to enroll with Molina.

- **Spouse**: A Subscriber who is also a Member can add a Spouse as long as You apply during the open enrollment period or during a period no longer than 60 days after any event listed below:

    - The Spouse loses "minimum essential coverage" through Government sponsored programs, Employer-sponsored plans, Individual market plans, or any other coverage designated as "minimum essential coverage" in compliance with the Affordable Care Act.
    - The date of Your marriage or the date the registration of Domestic Partnership is filed with the Washington Secretary of State;
    - The Spouse, who was not previously a citizen, national, or lawfully present individual, gains such status.

- **Children Under 26 Years of Age:** A Subscriber who is also a Member can add a Dependent under the age 26, including a stepchild, as long as You apply during the open enrollment period or during a period no longer than 60 days after any event listed below:

    - The child loses "minimum essential coverage" through Government sponsored programs, Employer-sponsored plans, Individual market plans, or any other coverage designated as "minimum essential coverage" as determined by the Affordable Care Act;
    - The child becomes a Dependent through marriage, Domestic Partnership registration**,** birth, or adoption;
    - The child, who was not previously a citizen, national, or lawfully present individual, gains such status.

- **Newborn Child:** Coverage for a newborn child is from the moment of birth. However, if You do not enroll the newborn child within 60 days, the newborn is covered for only 31 days (including the date of birth). Enrollment within 60 days will require additional premium to be charged as a result of the addition of the child up to three oldest covered children under 21 for a family coverage.

- **Adopted Child:** Coverage for a newly adopted child or child placed with You or Your Spouse for adoption, is the date of adoption, placement for adoption, or when You or Your Spouse assume the legal obligation for total or partial support in anticipation of adopting the child, whichever is earlier. However, if You do not enroll the adopted child or child placed with You or Your Spouse within 60 days, the child is covered for only 31 days (including the date of adoption, placement for adoption, or when the legal obligation for total or partial support was assumed, whichever is earlier). Enrollment within 60 days will require additional premium to be charged as a result of the addition of the child up to three oldest covered children under 21 for a family coverage.

Proof of the child's date of birth or qualifying event will be required.

Discontinuation of Dependent Benefits and Coverage: Benefits and Coverage for a Dependent will be discontinued on:

- The date the Dependent child attains age 26, unless the child is disabled and meets specified criteria. See the section titled "Age Limit for Children (Disabled Children)," above, for more information. Coverage for newborn children of a covered Dependent child will end when the covered Dependent child (or the Member under a Child-Only Coverage) is no longer eligible under this Agreement. The date the Dependent Spouse enters a final decree of divorce, annulment, dissolution of marriage, or termination of the domestic partnership from the Subscriber.

MEMBER IDENTIFICATION CARD

How do I Know if I am a Molina Member?
You get a Member identification (ID) card from Molina. Your ID card comes in the mail. Your ID card lists Your Primary Care Doctor's name and phone number. Carry Your ID card with You at all times. You must show Your ID card every time You get health care. If You lose Your ID card, call Molina toll-free at 1 (888) 858-3492. We will be happy to send You a new ID card.

If You have questions about a service, You can call Molina's Customer Support Center toll-free at 1 (888) 858-3492.

What Do I Do First?
Look at Your Molina Member ID card. Check that Your name and date of birth are correct. Your ID card will tell You the name of Your doctor. This person is called Your Primary Care Doctor or PCP. This is Your main doctor. Your ID card also contains the following information:

- Your name (Member)
- Your Member Identification Number (ID #)
- Your date of Birth (DOB)

- Your Primary Care Doctor's name (Provider)
- Your Primary Care Doctor's office phone number (Provider Phone)
- The name of the medical group Your PCP is associated with (Provider Group)
- Molina's 24 hours Nurse Advice Line toll-free number
- The toll-free number to Nurse Advice Line for Spanish speaking Members
- Toll free number for prescription related questions and the identifier for Molina's prescription drug benefit
- Toll free number for hospitals to notify Molina of admissions for Our Members
- Toll free number for emergency rooms to notify Molina of emergency room admissions for Our Members

Your ID card is used by health care providers such as Your Primary Care Doctor, pharmacist, hospital and other health care providers to determine Your eligibility for services through Molina. When accessing care You may be asked to present Your ID card before services are provided.

YOUR PRIVACY

Your privacy is important to us. We respect and protect Your privacy. Molina Healthcare uses and shares Your information to provide You with health benefits. Molina Healthcare wants to let You know how Your information is used or shared.

Your Protected Health Information

PHI means *protected health information*. PHI is health information that includes Your name, Member number or other identifiers, and is used or shared by Molina Healthcare.

Why does Molina Healthcare use or share Our Members' PHI?

- To provide for Your treatment
- To pay for Your health care
- To review the quality of the care You get
- To tell You about Your choices for care
- To run Our health plan
- To use or share PHI for other purposes as required or permitted by law.

When does Molina Healthcare need Your written authorization (approval) to use or share Your PHI?

Molina Healthcare needs Your written approval to use or share Your PHI for purposes not listed above.

What are Your privacy rights?

- To look at Your PHI
- To get a copy of Your PHI
- To amend Your PHI
- To ask us to not use or share Your PHI in certain ways
- To get a list of certain people or places We have given Your PHI

How does Molina Healthcare protect Your PHI?

Molina Healthcare uses many ways to protect PHI across Our health plan. This includes PHI in written word, spoken word, or in a computer. Below are some ways Molina Healthcare protects PHI:

- Molina Healthcare has policies and rules to protect PHI.
- Molina Healthcare limits who may see PHI. Only Molina Healthcare staff with a need to know PHI may use it.
- Molina Healthcare staff is trained on how to protect and secure PHI.
- Molina Healthcare staff must agree in writing to follow the rules and policies that protect and secure PHI
- Molina Healthcare secures PHI in Our computers. PHI in Our computers is kept private by using firewalls and passwords.

he above is only a summary. Our Notice of Privacy Practices has more information about how We use and share Our Members' PHI. **Our Notice of Privacy Practices is in the following section of this Policy and is on Our web site at www.molinahealthcare.com. You may also get a copy of Our Notice of Privacy Practices by calling Our Customer Support Center at 1-888-858-3492**

NOTICE OF PRIVACY PRACTICES
MOLINA HEALTHCARE OF WASHINGTON, INC.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Molina Healthcare of Washington, Inc. ("**Molina Healthcare**", "**Molina**", "**We**" or "**Our**") uses and shares protected health information about You to provide Your health benefits. We use and share Your information to carry out treatment, payment and health care operations. We also use and share Your information for other reasons as allowed and required by law. We have the duty to keep Your health information private and to follow the terms of this Notice. The effective date of this Notice is January 1, 2014.

PHI stands for these words, protected health information. PHI means health information that includes Your name, Member number or other identifiers, and is used or shared by Molina Healthcare.

Why does Molina Healthcare use or share Your PHI?
We use or share Your PHI to provide You with healthcare benefits. Your PHI is used or shared for treatment, payment, and health care operations.

For Treatment
Molina Healthcare may use or share Your PHI to give You, or arrange for, Your medical care. This treatment also includes referrals between Your doctors or other health care providers. For example, We may share information about Your health condition with a Specialist Physician. This helps the Specialist Physician talk about Your treatment with Your doctor.

For Payment
Molina Healthcare may use or share PHI to make decisions on payment. This may include claims, approvals for treatment, and decisions about medical need. Your name, Your condition, Your treatment, and supplies given may be written on the bill. For example, We may let a doctor know that You have Our benefits. We would also tell the doctor the amount of the bill that We would pay.

For Health Care Operations
Molina Healthcare may use or share PHI about You to run Our health plan. For example, We may use information from Your claim to let You know about a health program that could help You. We may also use or share Your PHI to solve Member concerns. Your PHI may also be used to see that claims are paid right.

Health care operations involve many daily business needs. It includes but is not limited to, the following:

- Improving quality;
- Actions in health programs to help Members with certain conditions (such as asthma);
- Conducting or arranging for medical review;
- Legal services, including fraud and abuse detection and prosecution programs;
- Actions to help us obey laws;

- Address Member needs, including solving complaints and grievances.

We will share Your PHI with other companies ("**business associates**") that perform different kinds of activities for Our health plan. We may also use Your PHI to give You reminders about Your appointments. We may use Your PHI to give You information about other treatment, or other health-related benefits and services.

When can Molina Healthcare use or share Your PHI without getting written authorization (approval) from You?

The law allows or requires Molina Healthcare to use and share Your PHI for several other purposes including the following:

Required by law

We will use or share information about You as required by law. We will share Your PHI when required by the Secretary of the Department of Health and Human Services (HHS). This may be for a court case, other legal review, or when required for law enforcement purposes.

Public Health

Your PHI may be used or shared for public health activities. This may include helping public health agencies to prevent or control disease.

Health Care Oversight

Your PHI may be used or shared with government agencies. They may need Your PHI for audits.

Research

Your PHI may be used or shared for research in certain cases.

Law Enforcement

Your PHI may be used or shared with police to help find a suspect, witness or missing person.

Health and Safety

Your PHI may be shared to prevent a serious threat to public health or safety.

Government Functions

Your PHI may be shared with the government for special functions. An example would be to protect the President.

Victims of Abuse, Neglect or Domestic Violence

Your PHI may be shared with legal authorities if We believe that a person is a victim of abuse or neglect.

Workers Compensation

Your PHI may be used or shared to obey Workers Compensation laws.

Other Disclosures

Your PHI may be shared with funeral directors or coroners to help them to do their jobs.

When does Molina Healthcare need Your written authorization (approval) to use or share Your PHI?

Molina Healthcare needs Your written approval to use or share Your PHI for a purpose other than those listed in this Notice. Molina needs Your authorization before We disclose Your PHI for the following: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a written approval that You have given us. Your cancellation will not apply to actions already taken by us because of the approval You already gave to us.

What are Your health information rights?
You have the right to:

- **Request Restrictions on PHI Uses or Disclosures (Sharing of Your PHI)**
  You may ask us not to share Your PHI to carry out treatment, payment or health care operations. You may also ask us not to share Your PHI with family, friends or other persons You name who are involved in Your health care. However, We are not required to agree to Your request. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request.

- **Request Confidential Communications of PHI**
  You may ask Molina Healthcare to give You Your PHI in a certain way or at a certain place to help keep Your PHI private. We will follow reasonable requests, if You tell us how sharing all or a part of that PHI could put Your life at risk. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request.

- **Review and Copy Your PHI**
  You have a right to review and get a copy of Your PHI held by us. This may include records used in making coverage, claims and other decisions as a Molina Healthcare Member. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request. We may charge You a reasonable fee for copying and mailing the records. In certain cases We may deny the request.

- **Amend Your PHI**
  You may ask that We amend (change) Your PHI. This involves only those records kept by us about You as a Member. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request. You may file a letter disagreeing with us if We deny the request.

- **Receive an Accounting of PHI Disclosures (Sharing of Your PHI)**
  You may ask that We give You a list of certain parties that We shared Your PHI with during the six years prior to the date of Your request. The list will not include PHI shared as follows:
  - for treatment, payment or health care operations;
  - to persons about their own PHI;
  - sharing done with Your authorization;
  - incident to a use or disclosure otherwise permitted or required under applicable law;
  - as part of a limited data set in accordance with applicable law.

We will charge a reasonable fee for each list if You ask for this list more than once in a 12-month period. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request.

You may make any of the requests listed above, or may get a paper copy of this Notice. Please call Our Customer Support Center at 1-888-858-3492.

What can You do if Your rights have not been protected?

You may complain to Molina Healthcare and to the Department of Health and Human Services if You believe Your privacy rights have been violated. We will not do anything against You for filing a complaint. Your care and benefits will not change in any way.

You may complain to us at:

Customer Support Center
P.O. Box 4004
Bothell, WA 98041
1-888-858-3492

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services at:

Office for Civil Rights
U.S. Department of Health and Human Services
2201 Sixth Avenue – M/S: RX-11
Seattle, WA 98121-1831

TDD (800)537-7697
FAX (206) 615-2297

What are the duties of Molina Healthcare?

Molina Healthcare is required to:

- Keep Your PHI private;
- Give You written information such as this on Our duties and privacy practices about Your PHI;
- Provide You with a notice in the event of any breach of Your unsecured PHI;
- Not use or disclose Your genetic information for underwriting purposes;
- Follow the terms of this Notice.

This Notice is Subject to Change

Molina Healthcare reserves the right to change its information practices and terms of this Notice at any time. If We do, the new terms and practices will then apply to all PHI We keep. If We make any material changes, Molina will post the revised Notice on Our web site and send the revised Notice, or information about the material change and how to obtain the revised Notice, in Our next annual mailing to Our members then covered by Molina.

Contact Information

If You have any questions, please contact the following office:

Customer Support Center
P.O. Box 4004
Bothell, WA 90841

1-888-858-3492

ACCESSING CARE

How Do I Get Medical Services Through Molina?
(Choice of Doctors and Providers; Facilities)

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHO OR WHAT GROUP OF PROVIDERS' HEALTH CARE SERVICES MAY BE OBTAINED.

Your Provider Directory includes a list of the Primary Care Providers and hospitals that are available to You as a Member of Molina. You may visit Molina's website at www.molinahealthcare.com to view Our online list of doctors.

The first person You should call for any healthcare is Your Primary Care Provider.

If You need hospital or similar services, You must go to a facility that is a Participating Provider. For more information about which facilities are with Molina, or where they are located, call Molina toll-free at 1 (888) 858-3492. You may get Emergency Services or out of area Urgent Care Services in any emergency room or urgent care center, wherever located.

If Medically Necessary Covered Services are not available through a Participating Provider, You may request Prior Authorization to allow referral to a non-Participating Provider for the specifically requested medical condition. Any such request will be reviewed by a Specialist Physician of the same specialty as the provider to whom a Referral is requested. Upon Medical Necessity review, approved authorizations will be treated as a Participating Provider Covered Service. We will reimburse the non-Participating Provider up to the lesser of any negotiated rate, or the Non-Participating Provider's usual and customary fees for such services.

Here is a chart to help You learn where to go for medical services. The services You may need are listed in the boxes on the left. Find the service You need, look in the box just to the right of it and You will find out where to go.

TYPE OF HELP YOU NEED:	WHERE TO GO. WHO TO CALL.
Emergency Services	Call 911 or go to the nearest emergency room. Even when outside Molina's network or Service Area, please call 911 or go to the nearest emergency room for Emergency care.
Urgent Care Services	Call Your PCP or Molina's 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750 or for Spanish 1 (866)648-3537 for directions. For out-of-area Urgent Care Services You may also go to the nearest urgent care center or emergency room.
A physical exam, wellness visit or immunizations	Go to Your PCP
Treatment for an illness or injury that is not	Go to Your PCP

TYPE OF HELP YOU NEED:	WHERE TO GO. WHO TO CALL.
an Emergency	
Family planning services, such as: • Pregnancy tests • Birth control • Sterilization	Go to any Participating Provider of Your choice. You do not need a Prior Authorization to get these services.
Tests and treatment for sexually transmitted diseases (STDs)	Go to any Participating Provider of Your choice. You do not need a Prior Authorization to get these services.
To see an OB/GYN (woman's doctor).	Women may go to any Participating Provider OB/GYN without a Referral or Prior Authorization. Ask Your doctor or call Molina's Customer Support Center if You do not know an OB/GYN.
For mental health or substance abuse evaluation	Go to a qualified mental health Participating Provider. You do not need a Referral or Prior Authorization to get a mental health or substance abuse evaluation.
For mental health or substance abuse therapy	For mental health or substance abuse therapy, a Referral from your qualified mental health Participating Provider is needed.
To see a Specialist Physician (for example, cancer or heart doctor)	Go to Your PCP first. Your doctor will give You a Referral if needed. If You need Emergency Services or out-of-area Urgent Services, get help as directed under Emergency Care or Urgent Care Services above
To have surgery	Go to Your PCP first. Your doctor will give You a Referral if needed. If You need Emergency Services or out-of-area Urgent Care Services, get help as directed under Emergency Care or Urgent Care Services above
To get a second opinion	Consult Your Provider Directory on Our website at www.molinahealthcare.com to find a Participating Provider for a second opinion.
To go to the Hospital	Go to Your PCP first. Your doctor will give You a Referral if needed. If You need Emergency Services or out-of-area Urgent Care Services, get help as directed under Emergency

TYPE OF HELP YOU NEED:	WHERE TO GO. WHO TO CALL.
	Care or Urgent Care Services above.
After-hours care	Call Your PCP for a Referral to an after-hours clinic or other appropriate care center. You can also call Molina's Nurse Advice Line toll-free at 1 (888) 275-8750 or for Spanish 1 (866)648-3537.

What is a Primary Care Provider? (Primary Care Physician, Primary Care Doctor or PCP)
A Primary Care Provider (or PCP) takes care of Your health care needs. A PCP knows You well. Call Your PCP when You are sick and You do not know what to do. You do not have to go to the emergency room unless You believe You have an Emergency Condition.

You may think that You should not see Your PCP until You are sick. That is not true.

Get to know Your PCP even when You are well. Go for yearly check-ups to stay healthy. Go to Your PCP for check-ups, tests and test results, shots, and – of course – when You are ill. Seeing Your PCP for check-ups allows problems to be found early. If You need special care, Your PCP will help You get it. Your PCP and You work together to keep You healthy.

If You want to know more about Your PCP or other Molina doctors, call Molina's Customer Support Center toll-free at 1 (888) 858-3492.

Choosing Your Doctor (Choice of Physician and Providers)
For Your health care to be covered under this Policy, Your health care services must be received from Molina Participating Providers (doctors, hospitals, specialists or medical clinics), except in the case of Emergency Services or out of area Urgent Services. Please see page 31 for more information about the coverage of Emergency Services and out of area Urgent Services.

Our Provider Directory will help You get started in making decisions about Your health care. You will find a listing of doctors, hospitals and Other Practitioners that are available under Molina's health plan. You will also learn some helpful tips on how to use Molina's services and benefits. Visit Molina's website at www.molinahealthcare.com to view Our online list of Participating Providers.

You can find the following in Your Provider Directory:

- Names
- Addresses
- Telephone numbers
- Languages spoken
- Availability of service locations
- Professional qualifications (e.g. board certification)
- You can also find out if a Participating Provider is taking new patients. This includes doctors,

hospitals, specialists, or medical clinics

You can also find whether or not a Participating Provider, including doctors, hospitals, Specialist Physicians, or medical clinics, is accepting new patients in Your Provider Directory.

Note: Some hospitals and providers may not provide some of the services that may be covered under this Policy that You or Your family member might need: family planning, birth control, including Emergency contraception, sterilization, (including tubal ligation at the time of labor and delivery), or pregnancy termination services. You should obtain more information before You enroll. Call Your doctor, medical group, or clinic, or call the Customer Support Center toll-free at 1 (888) 858-3492 to make sure that You can get the health care services that You need.

How Do I Choose a Primary Care Provider (PCP)?

It's easy to choose a Primary Care Provider (or PCP). Simply use Our Provider Directory to select from a list of doctors. You may want to choose one doctor who will see Your whole family. Or, You may want to choose one doctor for Yourself and another one for Your family members.

Your PCP knows You well and takes care of all Your medical needs. Choose a PCP as soon as You can. It is important that You choose a PCP that You feel comfortable with.

Call and schedule Your first visit to get to know Your PCP. If You need help making an appointment, call Molina toll-free at 1 (888) 858-3492. Molina can also help You find a PCP. Tell us what is important to You in choosing a PCP. We are happy to help You. Call the Customer Support Center if You want more information about Your Molina doctor.

What if I Don't Choose a Primary Care Provider?

Molina asks that You select a Primary Care Provider within 30 days of joining Molina. However, if You don't choose a PCP, Molina will choose one for You.

Changing Your Doctor

What if I Want to Change my Primary Care Provider?

You can change Your PCP at any time. All changes completed by the end of the month will be in effect on the first day of the following calendar month. But first visit Your doctor. Get to know Your PCP before changing. Having a good relationship with Your PCP is important to Your health care. Call the Customer Support Center if You want more information about Your Molina doctor.

Can my Doctor Request that I Change to a Different Primary Care Provider?

Your doctor may request that You be changed to a different PCP for any of the following reasons:

- You are not following medical instructions (non-compliant behavior)
- You are being abusive, threatening or have violent behavior
- Doctor-patient relationship breakdown

How do I Change my Primary Care Provider?

Call Molina toll-free at 1 (888) 858-3492, Monday through Friday, 8:00 a.m. to 5:00 p.m. PT.

You may also visit Molina's website at www.molinahealthcare.com to view Our online list of doctors. Let us help You make the change.

Sometimes You may not be able to get the PCP You want. This may happen because:

- The PCP is no longer a Participating Provider with Molina.
- The PCP already has all the patients he or she can take care of right now.

What if my Doctor or Hospital is no Longer with Molina?
If Your doctor (PCP or Specialist Physician) is no longer with Molina, We will send You a letter to let You know. The letter will tell You how the change affects You. If Your PCP is no longer with Molina, You can choose a different doctor. Our Molina Customer Support Center staff can help You make a choice.

If You are assigned to a PCP that is ending a contract with Molina, then Molina will provide You 60 days advance written notice of the contract ending between Molina and the PCP.

Continuity of Care
If You have been getting care from a doctor that is ending a contract with Molina, You will have the right to continue to receive Covered Services from Your PCP for at least 60 days from the date of the notice of termination You receive from Molina.

If You want to request that You stay with the same doctor for continuity of care, call Molina's Customer Support Center toll-free at 1 (888) 858-3492. If You are deaf or hard of hearing, call us with the National Relay Service by dialing 711.

Please note that the right to temporary continuity of care, as described above, does not apply to a newly enrolled Member undergoing treatment from a doctor or hospital that is not a Participating Provider with Molina.

24-Hour Nurse Advice Line

If You have questions or concerns about You or Your family's health, call Our 24-Hour Nurse Advice Line at 1 (888) 275-8750 or for Spanish 1 (866)648-3537, or if You are deaf or hard of hearing access Nurse Advice with the National Relay Service by dialing 711. The Nurse Advice Line is staffed by Registered Nurses. They are open 24 hours a day, 365 days a year.

Your doctor's office should give You an appointment for the listed visits in this time frame:

Appointment Type	When You should get the appointment
Emergency Care	Available 24 hours / 7 days
Urgent care	Within 48 hours of the appointment request
Preventive Care – Non-urgent	Within 30 calendar days of request

Routine or non-urgent care appointments	Within 10 calendar days of request
After-Hours Care	Available 24 hours / 7 days
Office Waiting Time	Should not exceed 30 minutes

What is a Prior Authorization?

A **Prior Authorization** is a request for You to receive a Covered Service from Your doctor. Molina and Your doctor review the Medical Necessity of Your care before the care or service is given to ensure it is appropriate for Your specific condition.

You do not need Prior Authorization for the following services:

- Emergency or Urgent Care Services
- Female Members may self-refer to an OB/GYN
- Family planning services
- Human Immunodeficiency Virus (HIV) testing & counseling
- Services for sexually transmitted diseases

You must get Prior Authorization for the following services (except when for Emergency Services and Urgent Care Services):

- All inpatient admissions
- Cardiac and pulmonary rehabilitation
- Certain high dollar injectable drugs and medications not listed on the Molina Drug Formulary
- Cosmetic, plastic and reconstructive procedures
- Dental general anesthesia for dental restorations in Members 7 years old or older
- Dialysis – notification only
- Durable Medical Equipment that costs more than $500
- All customized orthotics / prosthetics and braces (for example special braces, shoes or shoe supports) wheelchairs (for example manual, electric or scooters) and internally implanted hearing devices
- Enteral formulas and nutritional supplements and related supplies
- Experimental and Investigational procedures
- Genetic Testing (Medically Necessary)
- Habilitative services
- Home health care
- Hospice inpatient care – notification only
- Imaging (special testing such as CT (computed tomography), MRI (magnetic resonance imaging), MRA (magnetic resonance angiogram), cardiac scan and PET (positron emission tomography) scan
- Mental health services
- Office based podiatry (foot) surgery
- Outpatient hospital / ambulatory surgery center procedures subject to exceptions*
- Pain management services and procedures
- Pregnancy and delivery – notification only
- Rehabilitative services
- Specialty pharmacy

- Substance Abuse Disorder services
- Transplant evaluation and related services
- Transportation (non-emergency Medically Necessary ground and air ambulance, for example – medi-van, wheel chair van, ambulance, etc.)
- Any other services listed as requiring Prior Authorization in this Policy

*Call Molina's Customer Support Center at 1 (888) 858-3492 if You need to determine if Your service needs Prior Authorization.

If Molina denies a request for a Prior Authorization, You may appeal that decision as described below. If You and Your provider decide to proceed with services that have been denied a Prior Authorization for benefits under this Policy, You may be responsible for the charges for the denied services.

Approvals are given based on medical need. If You have questions about how a certain service is approved, call Molina toll-free at 1 (888) 858-3492. If You are deaf or hard of hearing, dial 711 for the National Relay Service. We will be happy to send You a general explanation of how that type of decision is made or send You a general explanation of the overall approval process if You request it. Routine Prior Authorization requests will be processed within five (5) business days from receipt of all information reasonably necessary and requested by Molina to make the determination, and no longer than 14 calendar days from the receipt of the request. Medical conditions that may cause a serious threat to Your health are processed within 72 hours from receipt of all information reasonably necessary and requested by Molina to make the determination or, if shorter, the period of time required under Section 2719 of the federal Public Health Services Act and subsequent rules and regulations. Molina processes requests for urgent specialty services immediately by telephone.

If a service is not Medically Necessary or is not a Covered Service, request for the service may be denied. You will get a letter telling You why it was denied. You or Your doctor may appeal the decision. The denial letter will tell You how to appeal. These instructions are also noted on page 71 of this Policy.

Standing Approvals
If You have a condition or disease that requires specialized medical care over a prolonged period of time, You may need a standing approval. If You receive a standing approval to a Specialist Physician, You will not need to get a Referral or Prior Authorization every time You see that Specialist Physician. Also, if Your condition or disease is life threatening, worsening, or disabling, You may need to receive a standing approval to a Specialist Physician or specialty care center. They have the expertise to treat the condition or disease. To get a standing approval, call Your Primary Care Doctor. Your Primary Care Doctor will work with Molina's physicians and specialists to ensure You receive a treatment plan based on Your medical needs. If You have any difficulty getting a standing approval, call Molina toll-free at 1 (888) 858-3492 or dial 711 for the National Relay Service. If, after calling the plan, You feel Your needs have not been met, please refer to Molina's complaint process on page 71.

Second Opinions
You or Your PCP may want another doctor (a PCP or a Specialist Physician) to review Your condition. This doctor looks at Your medical record and may see You. This new doctor may suggest a plan of care. This is called a second opinion. Please consult Your Provider Directory

on Our website at www.molinahealthcare.com to find a Participating Provider for a second opinion.

Here are some, but not all the reasons why You may get a second opinion:

- Your symptoms are complex or confusing. Your doctor is not sure the diagnosis is correct.
- You have followed the doctor's plan of care for a while and Your health has not improved.
- You are not sure that You need surgery or think You need surgery.
- You do not agree with what Your doctor thinks is Your problem. You do not agree with Your doctor's plan of care.
- Your doctor has not answered Your concerns about Your diagnosis or plan of care.

Emergency and Urgent Care Services

What is an Emergency?
Emergency Services mean health care services needed to observe, evaluate, stabilize or treat an **Emergency Medical Condition.** An Emergency Condition includes a medical or psychiatric medical condition having acute and severe symptoms (including severe pain) or involving active labor. If immediate medical attention is not received, an Emergency could result in any of the following:

- **Placing the patient's or the patient's unborn child's health in serious danger.**
- **Serious damage to bodily functions.**
- **Serious dysfunction of any bodily organ or part.**

Emergency Services also includes Emergency contraceptive drug therapy.

Emergency Services includes Urgent Care Services that cannot be delayed in order to prevent serious deterioration of health from an unforeseen condition or injury.

How do I get Emergency care?

Emergency care is available 24 hours a day, 7 days a week for Molina Members.

If You think You have an Emergency, wherever You are:

- Call 911 right away.
- Go to the closest hospital or emergency room.

When You go for Emergency health care, carry Your Molina Member ID card. The Emergency Room Copayment Cost Share will be identified on Your Molina Member ID card.

If You are not sure if You need Emergency health care but You need medical help, call Your PCP. Or call Our 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750 or for Spanish 1 (866)648-3537. The Nurse Advice Line is staffed by registered nurses (RNs). You can call the

Nurse Advice Line 24 hours a day, 365 days a year. If You are deaf or hard of hearing please dial 711 for the National Relay Service.

Hospital emergency rooms are only for real Emergencies. These are not good places to get non-Emergency care. They are often very busy and must care first for those whose lives are in danger. Please do not go to a hospital emergency room if Your condition is not an Emergency.

What if I'm away from Molina's Service Area and I need Emergency health care?
Go to the nearest emergency room for care. Please contact Molina within 24 hours, or when medically reasonable, of getting urgent or Emergency health care. Call toll-free at 1 (888) 858-3492. If You are deaf or hard of hearing, dial 711 for the National Relay Service. When You are away from Molina's Service Area, only Urgent Care Services or Emergency Services are covered.

What if I need after-hours care or Urgent Care Services?
Urgent Care Services are available when You are within or outside of Molina's Service Area. Urgent Care Services are those services needed to prevent the serious deterioration of one's health from an unforeseen medical condition or injury.

If You get ill after hours or need Urgent Care Services, call Your PCP or Molina's 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750 or for Spanish 1 (866)648-3537 for directions. Our nurses can help You any time of the day or night. They will tell You what to do or where to go to be seen.

If You are within Molina's Service Area and have already asked Your PCP the name of the urgent care center that You are to use, go to the urgent care center. It is best to find out the name of the urgent care center ahead of time. Ask Your doctor for the name of the urgent care center and the name of the hospital that You are to use.

If You are outside of Molina's Service Area, You may also go to the nearest urgent care center or emergency room.

Complex Case Management
What if I have a difficult health problem?
Living with health problems and dealing with the things to manage those problems can be hard. Molina has a program that can help. The Complex Case Management program is for Members with difficult health problems that need extra help with their health care needs.
The program allows You to talk with a nurse about Your health problems. The nurse can help You learn about those problems and teach You how to better manage them. The nurse may also work with Your family or caregiver and provider to make sure You get the care You need. There are several ways You can be referred for this program. There are also certain requirements that You must meet. This program is voluntary. You can choose to be removed from the program at any time.

If You would like information about this program, please call the Customer Support Center toll-free at 1 (888) 858-3492. If You are deaf or hard of hearing, dial 711 for the National Relay Service.

Pregnancy

What if I am pregnant?
If You think You are pregnant—or as soon as You know You are pregnant—please call for an appointment to begin Your prenatal care. Early care is very important for You and Your baby's health and well-being.

You may choose any of the following for Your prenatal care:

- Licensed obstetrician/gynecologist (OB/GYN)
- Nurse practitioner (trained in women's health)
- Physician assistant
- Certified midwives

You can make an appointment for prenatal care without seeing Your PCP first. To receive benefits under this Agreement, You must pick a provider who is a Participating Provider. If You need help choosing an OB/GYN or other provider or if You have any questions, call Molina toll-free at 1 (888) 858-3492 Monday through Friday from 8:00 a.m. to 5:00 p.m. PT. We will be happy to assist You.

Molina offers a special program called Motherhood Matters to Our pregnant Members. This program provides important information about diet, exercise and other topics related to Your pregnancy. For more information, call the Motherhood Matters pregnancy program toll-free at 1 (877) 665-4628, Monday through Friday, 8:00 a.m. to 5:00 p.m.

Accessing Care for Members with Disabilities

Americans with Disabilities Act
The Americans with Disabilities Act (ADA) prohibits discrimination on the basis of disability. The ADA requires Molina and its contractors to make reasonable accommodations for patients with disabilities.

Physical Access
Molina has made every effort to ensure that Our offices and the offices of Molina doctors are accessible to persons with disabilities. If You are not able to locate a doctor who meets Your needs, please call Molina toll-free at 1 (888) 858-3492 or call us with the National Relay Service by dialing 711 and a Customer Support Center Representative will help You find another doctor.

Access for the Deaf or Hard of Hearing
Call Molina's Customer Support Center through the National Relay Service by dialing 711.

Access for Persons with Low Vision or who are Blind
This Policy and other important plan materials will be made available in accessible formats for persons with low vision or who are blind. Large print and enlarged computer disk formats are available and this Policy is also available in an audio format. For accessible formats, or for direct help in reading the Policy and other materials, please call Molina toll-free at 1 (888) 858-3492. Members who need information in an accessible format (large size print, audio, and Braille) can ask for it from Molina's Customer Support Center.

Disability Access Grievances
If You believe Molina or its doctors have failed to respond to Your disability access needs, You may file a grievance with Molina.

BENEFITS AND COVERAGE

Molina covers the services described in the section titled "What is Covered Under My Plan?", below, subject to the exclusions, limitations, and reductions set forth in this Policy, only if all of the following conditions are satisfied:

- You are a Member on the date that You receive the Covered Services
- The Covered Services are Medically Necessary
- The services are Covered Services in this Policy, inclusive of applicable services required by state and federal law.
- You receive the Covered Services from Participating Providers inside Our Service Area for this Policy offered through the Health Benefit Exchange, except where specifically noted to the contrary in this Policy – e.g., in the case of an Emergency or need for out-of-area Urgent Care Services.

The services Molina covers under this Policy are those described in this Policy and inclusive of applicable state and federal laws, subject to any exclusions, limitations, and reductions described in this Policy.

COST SHARING (Money You Will Have to Pay to Get Covered Services)
Cost Sharing is the Deductible, Copayment, or Coinsurance that You must pay for Covered Services under this Agreement. The Cost Sharing amount You will be required to pay for each type of Covered Service is listed in the Molina of Washington, Inc. Schedule of Benefits at the beginning of this Policy.

You must pay Cost Sharing for Covered Services, except for preventive services included in the Essential Health Benefits (as required by the Affordable Care Act) that are provided by Participating Providers. Cost Sharing for Covered Services is listed in the Molina of Washington, Inc. Schedule of Benefits at the beginning of this Policy. Cost Sharing towards Essential Health Benefits may be reduced or eliminated for certain eligible Members, as determined by the Health Benefit Exchange's rules.

YOU SHOULD REVIEW THE MOLINA HEALTHCARE OF WASHINGTON, INC. SCHEDULE OF BENEFITS CAREFULLY TO UNDERSTAND WHAT YOUR COST SHARING WILL BE.

Annual Out-of-Pocket Maximum

For Individuals - is the total amount of Cost Sharing You, as an individual Member, will have to pay for Covered Services in a calendar year. The Cost Sharing and individual Annual Out-of-Pocket Maximum amounts applicable to Your Certificate are specified in Molina Healthcare of Washington, Inc. Schedule of Benefits. For this Certificate, Cost Sharing includes payments You make towards any Deductibles, Copayments or Coinsurance. Once

Your total Cost Sharing in a calendar year reaches the specified individual Annual Out-of-Pocket Maximum amount, We will pay 100% of the charges for Covered Services for the remainder of the calendar year. Amounts that You pay for services that are not Covered Services under this Certificate will not count towards the individual Annual Out-of-Pocket Maximum.

For Family (2 or more Members) – is the total amount of Cost Sharing that at least two or more Members of a family will have to pay for Covered Services in a calendar year. The Cost Sharing and family Annual Out-of-Pocket Maximum amounts applicable to Your Certificate are specified in the Molina Healthcare of Washington, Inc. Schedule of Benefits. For this Certificate, Cost Sharing includes payments You make towards any Deductibles, Copayments or Coinsurance. Once the total Cost Sharing made by at least two or more Members of a family reaches the specified Annual Out-of-Pocket Maximum amount, We will pay 100% of the charges for Covered Services for all enrolled family Members for the remainder of the calendar year. Amounts that You pay for services that are not Covered Services under this Certificate will not count towards the family Annual Out-of-Pocket Maximum.

Coinsurance
Coinsurance is a percentage of the charges for Covered Services You must pay when You receive Covered Services. The Coinsurance amount is calculated as a percentage of the rates that Molina has negotiated with the Participating Provider. Coinsurances are listed in the Molina of Washington, Inc. Schedule of Benefits. Some Covered Services do not have Coinsurance, and may apply a Deductible or Copayment.

Copayment
A Copayment is a specific dollar amount You must pay when You receive Covered Services. Copayments are listed in the Molina of Washington, Inc. Schedule of Benefits. Some Covered Services do not have a Copayment, and may apply a Deductible or Coinsurance.

Deductible
Deductible is the amount You must pay in a calendar year for Covered Services You receive before Molina will cover those services at the applicable Copayment or Coinsurance. The amount that You pay towards Your Deductible is based on the rates that Molina has negotiated with the Participating Provider. Deductibles are listed in the Molina Healthcare of Washington, Inc. Schedule of Benefits. Please refer to the Molina Healthcare of Washington, Inc. Schedule of Benefits to see what Covered Services are subject to the Deductible and the Deductible amount. Your product may have separate Deductible amounts for specified Covered Services. If this is the case, amounts paid towards one type of Deductible cannot be used to satisfy a different type of Deductible. When Molina covers services at “no charge” subject to the Deductible and You have not met Your Deductible amount, You must pay the charges for the services. When preventive services covered by this Agreement are included in the Essential Health Benefits, You will not pay any Deductible or other Cost Sharing towards such preventive services.
There may be a Deductible listed for an individual Member and a Deductible for an entire family. If You are a Member in a family of two or more Members, You will meet the Deductible either:

(iii) when You meet the Deductible for the individual Member; or

(iv) when Your family meets the Deductible for the family.

For example, if You reach the Deductible for the individual Member, You will pay the applicable Copayment or Coinsurance for Covered Services for the rest of the calendar year, but every other Member in Your family must continue to pay towards the Deductible until Your family meets the family Deductible

General Rules Applicable to Cost Sharing
All Covered Services have a Cost Sharing, unless specifically stated or until You pay the Annual Out-of-Pocket Maximum. Please refer to the Molina of Washington, Inc. Schedule of Benefits at the beginning of this Policy to determine the Cost Sharing amount You will be required to pay for each type of Covered Service listed.

You are responsible for the Cost Sharing in effect on the date You receive Covered Services, except as follows:

- For items ordered in advance, You pay the Cost Sharing in effect on the order date (although Molina will not cover the item unless You still have coverage for it on the date You receive it) and You may be required to pay the Cost Sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription.

Receiving a Bill
In most cases, Participating Providers will ask You to make a payment toward Your Cost Sharing at the time You check in. Keep in mind that this payment may cover only a portion of the total Cost Sharing for the Covered Services You receive, and Participating Provider will bill You for any additional Cost Sharing amounts that are due.

How Your Coverage Satisfies the Affordable Care Act
Your Covered Services include Essential Health Benefits as determined by the Affordable Care Act. If non-EHB coverage is included in Your Policy, those Covered Services will be set out in this Policy as well.

Your Essential Health Benefits coverage includes at least the 10 categories of benefits identified in the definition. You cannot be excluded from coverage in any of the 10 EHB categories except You will not be eligible for pediatric services (including pediatric dental separately provided through the Health Benefit Exchange and vision) that are Covered Services under this Agreement if You are 19 years of age or older.

The Affordable Care Act provides certain rules for Essential Health Benefits that will apply to how Molina administers Your coverage under this Policy. For example, under the Affordable Care Act, Molina is not allowed to set lifetime limits or annual limits on the dollar value of Essential Health Benefits provided under this Policy. When EHB preventive services are provided by a Participating Provider, You will not have to pay any Cost Sharing amounts. In

addition, Molina must ensure that the Cost Sharing which You pay for all Essential Health Benefits does not exceed an Annual Out of Pocket Limit that is determined under the Affordable Care Act. For the purposes of this Policy, Cost Sharing refers to any costs which a Member is required to pay for receipt of Essential Health Benefits. Such Cost Sharing includes, Deductibles, Coinsurance, Copayments or similar charges, but excludes Premiums, and Your spending for non-Covered Services.

Making Your Coverage More Affordable
For qualifying Subscribers, there may be assistance to help make the Policy that You are purchasing under this Agreement more affordable. If You have not done so already, please contact the Health Benefit Exchange to determine if You are eligible for tax credits to reduce Your Premiums and/or Your Cost Sharing responsibility toward the Essential Health Benefits. The Health Benefit Exchange also will have information about any annual limits on Cost Sharing towards Your Essential Health Benefits. The Health Benefit Exchange can assist You in determining whether You are a qualifying Indian who has limited or no Cost Sharing responsibilities for Essential Health Benefits. Molina will work with the Health Benefit Exchange in helping You.

Molina does not determine or provide Affordable Care Act tax credits.

What is Covered Under My Plan?
This section tells You what medical services Molina covers for the Member, also known as Member's Benefits and Coverage or Covered Services.

In order for a service to be covered, **it must be Medically Necessary**.

You have the right to appeal if a service is denied. Turn to page 71 for information on how You can have Your case reviewed (also see External Review or Appeal on page 73).

Your care must not be Experimental or Investigational. However, You may ask to be part of Experimental or Investigational care. Go to page 28 for information. Molina also may cover routine medical costs for Members in Approved Clinical Trials. Go to page 47 to find out more.

Certain medical services described in this section will only be covered by Molina if the Member obtains Prior Authorization *before* seeking treatment for such services. For a further explanation of Prior Authorization and a list of Covered Services which require Prior Authorization, go to pages 27-29. However, Prior Authorization will never apply to treatment of Emergency Conditions or for Urgent Care Services.

OUTPATIENT PROFESSIONAL SERVICES

PREVENTIVE CARE AND SERVICES

Preventive Services and the Affordable Care Act
Under the Affordable Care Act and as part of Your Essential Health Benefits, Molina will cover the following government-recommended preventive services, without Your paying any Cost Sharing:

- Those evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved;

- Those immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;

- With respect to infants, children, and adolescents, such evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and

- With respect to women, those evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

All preventive care must be furnished by a Participating Provider to be covered under this Agreement.

As new recommendations and guidelines for preventive care are published by the government sources identified above, they will become covered under this Agreement as they become available to Molina during the product year. Coverage will be as required by the Affordable Care Act.

If an existing or new government recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a preventive service, then Molina may impose reasonable coverage limits on such preventive care as long as they are consistent with the Affordable Care Act and applicable Washington law. These coverage limitations also are applicable to the preventive care benefits listed below.

To help You understand and access Your benefits, preventive services for adults and children which are covered under this Policy are listed below.

Preventive Care for Children and Adolescents
The following preventive care services are covered and recommended for all children and adolescents (through age 18) without Your paying any Cost Sharing if furnished by a Participating Provider:

- Complete health history
- Physical exam including growth assessment
- Nutritional health assessment
- Vision screening
- Dental screening
- Speech and hearing screening
- Immunizations*
- Laboratory tests, including tests for anemia, diabetes, cholesterol and urinary tract infections
- Tuberculosis (TB) screening

- Sickle cell trait screening, when appropriate
- Health education
- Meeting with the parent, guardian or emancipated minor to talk about the meaning of the exam
- Lead blood level testing. Parents or legal guardians of Members ages six months to 72 months are entitled to receive from their PCP; oral or written anticipatory guidance on lead exposure, This includes how children can be harmed by exposure to lead, especially lead-based paint. When Your PCP does a blood lead-screening test it is very important to follow-up and get the blood test results. Contact Your PCP for additional questions.
- All comprehensive perinatal services are covered. This includes: perinatal and postpartum care, health education, nutrition assessment and psychological services.
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, including those provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration, are covered for Members under the age of 21, including those with special health care needs.
- Depression screening: adolescents
- Hemoglobinopathies screening: newborns
- Hypothyroidism screening: newborns
- Iron supplementation in children when prescribed by a PCP
- Obesity screening and counseling: children
- Phenylketonuria (PKU) screening: newborns
- Gonorrhea prophylactic medication: newborns

*If You take Your child to Your local health department or the school has given Your child any shot(s), make sure to give a copy of the updated shot record (immunization card) to Your child's PCP.

Preventive Care for Adults and Seniors
The following outpatient preventive care services are covered and recommended for all adults, including seniors without Your paying any Cost Sharing if furnished by a Participating Provider:

- Medical history and physical exam
- Blood pressure check
- Cholesterol check
- Breast exam for women (based on Your age)
- Mammogram, both diagnostic and screening, for women (based on Your age)
- Pap smear for women (based on Your age) and health status including human papilloma virus
- (HPV) screening test
- Prostate specific antigen testing
- Tuberculosis (TB) screening
- Colorectal cancer screening (based on Your age or increased medical risk)
- Cancer screening
- Osteoporosis screening for women (based on Your age)
- Immunizations

- Laboratory tests for diagnosis and treatment (including diabetes and STD's)
- Health management, including diabetes education and self-management training and chronic disease management
- Family planning services
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam
- Bacteriuria screening: pregnant women
- Folic acid supplementation
- Hepatitis B screening: pregnant women
- Breastfeeding support, supplies counseling
- Rh incompatibility screening: first pregnancy visit
- Rh incompatibility screening: 24-28 weeks gestation
- Screening for gestational diabetes
- Hearing exams and screenings
- Eye exams and preventive vision screenings
- Abdominal aortic aneurysm screening: men
- Alcohol misuse counseling
- Anemia screening: women
- Aspirin to prevent cardiovascular disease (when prescribed by a Participating Provider)
- Fluoride as recommended by, the United States Preventive Services Task Force, when obtained with a prescription order
- BRCA counseling about breast cancer preventive medication
- Chlamydial infection screening: women
- Depression screening: adults
- Healthy diet counseling
- Obesity screening and counseling: adults
- STDs and HIV screening and counseling
- Tobacco use counseling and interventions, including smoking cessation drugs when prescribed by a Participating Provider
- Well-woman visits
- Screening and counseling for interpersonal and domestic violence: women

PHYSICIAN SERVICES

We cover the following outpatient physician services:

- Prevention, diagnosis, and treatment of illness or injury
- Diagnostic procedures, including colonoscopies; cardiovascular testing, including pulmonary function studies; and neurology/neuromuscular procedures
- Visits to the doctor's office
- Routine pediatric and adult health exams
- Specialist consultations when referred by Your PCP (for example, a heart doctor or cancer doctor)
- Injections and treatments when provided or referred by Your PCP
- Physician care in or out of the hospital
- When referred by a physician, neurodevelopmental therapy through age 6, consisting of

physical, occupational and speech therapy and maintenance to restore or improve function based on developmental delay
- Consultations and well-child care
- If You are a female Member, You may also choose to see an obstetrician/gynecologist (OB/GYN) for routine examinations and prenatal care, and may select an OB/GYN as Your PCP.
- Outpatient maternity care including medically necessary supplies for a home birth; services for complications of pregnancy, including fetal distress, gestational diabetes and toxemia; services of a certified nurse midwife and Other Practitioners; and related laboratory services.

HABILITATIVE SERVICES
We cover Medically Necessary habilitative health care services and devices that are designed to assist individuals acquiring, retaining or improving self-help, socialization, and adaptive skills and functioning necessary for performing routine activities of daily life successfully in their home and community based settings. These services may include physical therapy, occupational therapy, speech therapy, aural therapy and durable medical equipment. These services include services delivered in a school-based health center setting that are not delivered pursuant to any Individual Educational Plan (IEP) under the federal Individuals with Disabilities Education Act of 2004 (IDEA).

REHABILITATIVE SERVICES
We cover Medically Necessary rehabilitative services that help injured or disabled Members resume activities of daily living. The goal of these services is for the Member to resume routine activities of daily life usually requiring physical therapy, speech therapy and occupational therapy (limited to 25 visits for the combined services per calendar year), in a setting appropriate for the level of disability or injury. Services include up to 10 spinal manipulations without referral per calendar year and up to 12 acupuncture services without referral per calendar year. For rehabilitative services, including rehabilitative services received in a Participating Provider's office, You pay the "Rehabilitative Services" Cost Sharing amount stated in the Schedule of Benefits, rather than the Office Visit Cost Sharing amount.

OUTPATIENT MENTAL HEALTH SERVICES

We cover the following outpatient care when provided by Participating Providers who are physicians or other licensed health care professionals acting within the scope of their license:

- Individual and group mental and behavioral health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient services for the purpose of monitoring drug therapy

We cover outpatient mental and behavioral health services only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, current edition, Text Revision (DSM), including eating disorders associated with a diagnosis of a DSM categorized mental health condition, that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the DSM identifies as something other than a "mental disorder."

"**Mental Disorders**" include the following conditions:

- Severe Mental Illness of a person of any age. "**Severe Mental Illness**" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa.

OUTPATIENT SUBSTANCE ABUSE DISORDER SERVICES
We cover the following outpatient care for treatment of Substance Abuse Disorders:

- Day-treatment programs
- Intensive outpatient programs
- Individual and group chemical dependency counseling
- Medical treatment for withdrawal symptoms
- Individual chemical dependency evaluation and treatment
- Group chemical dependency treatment
- Home healthcare services when provided by qualified providers and subject to Home Healthcare services limitations
- Acupuncture treatment services

We do not cover services for alcoholism, drug abuse, or drug addiction except as otherwise described in this "Substance Abuse Disorder Services" section.

DENTAL AND ORTHODONTIC SERVICES
We do not cover most dental and orthodontic services, but We do cover some dental and orthodontic services as described in this "Dental and Orthodontic Services" section for all Members.

Dental Services for Radiation Treatment
We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare Your jaw for radiation therapy of cancer or neoplastic diseases in Your head or neck if a Participating Provider physician provides the services or if Molina authorizes a Referral to a dentist.

Dental Anesthesia
For dental procedures, We cover general anesthesia and the Participating Provider facility's services associated with the anesthesia if all of the following are true:

- You are under age 9, or You are physically or developmentally disabled, or Your health is compromised
- Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
- The dental procedure would not ordinarily require general anesthesia

We do not cover most other services related to the dental procedure, such as the dentist's services, unless included in this section. For Dental Anesthesia services, Coinsurance Cost Share will apply, for either Outpatient Hospital/Facility or Inpatient Hospital/Facility settings.

Trauma
We cover emergency dental services for injury to natural teeth, including oral surgery due to injury and trauma.

Dental and Orthodontic Services for Cleft Palate
We cover dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic services, if they meet all of the following requirements:

- The services are an integral part of a reconstructive surgery for cleft palate.
- A Participating Provider provides the services or Molina authorizes a Referral to a Non-Participating Provider who is a dentist or orthodontist.

Services to Treat Temporomandibular Joint Syndrome ("TMJ")
We cover the following services to treat temporomandibular joint syndrome (also known as "TMJ")

- Medically Necessary medical non-surgical treatment (e.g., splint and physical therapy) of TMJ;
- Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed.

For Covered Services related to dental or orthodontic care in the above sections, You will pay the Cost Sharing You would pay if the services were not related to dental or orthodontic care. For example, see "Inpatient Hospital /Facility Services" in the Molina of Washington, Inc. Schedule of Benefits for the Cost Sharing that applies for hospital inpatient care.

PEDIATRIC VISION SERVICES
We cover the following vision services for Members under the age of 19:

- Routine vision screening and eye exam, including dilation as professionally indicated, and with refraction every calendar year.
- Prescription glasses: frames and lenses, limited to one pair of prescription glasses once every 12 months.
- Covered frames include a limited selection of frames. Participating Providers will show the limited selection of frames available to You under this product. Frames that are not within the limited selection of frames under this product are not covered.
- Prescription Lenses: include single vision, lined bifocal, lined trifocal, lenticular lenses and polycarbonate lenses. Lenses include scratch resistant coating and UV protection.
- Prescription Contact Lenses: limited to one year supply every 12 months, in lieu of prescription lenses and frames; includes evaluation, fitting and follow-up care. Also covered if Medically Necessary, in lieu of prescription lenses and frames, for the treatment of:

    - Aniridia
    - Aniseikonia
    - Anisometropia
    - Aphakia
    - Corneal disorders
    - Irregular astigmatism

- Keratoconus
- Pathological myopia
- Post-traumatic disorders

- Low vision optical devices are covered including low vision services training, and instruction to maximize remaining usable vision. Follow-up care is covered when services are Medically Necessary and Prior Authorization is obtained. With Prior Authorization, coverage includes:

  - one comprehensive low vision evaluation every 5 years;
  - high-power spectacles, magnifiers, and telescopes as Medically Necessary; and
  - follow-up care – four visits in any five-year period.

Laser corrective surgery is not covered.

FAMILY PLANNING

We cover family planning services to help determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, You pick a doctor who is located near You to receive the services You need. Our Primary Care Physicians and OB/GYN Specialist Physicians are available for family planning services. You can do this without having to get permission from Molina. (Molina pays the doctor or clinic for the family planning services You get.) Family planning services include:

- Health management and counseling to help You make informed choices and to understand birth control methods.
- Limited history and physical examination.
- Laboratory tests if medically indicated as part of deciding what birth control methods You might want to use.
- Prescription birth control supplies, devices, birth control pills, including Depo-Provera.
- Administration, insertion, and removal of contraceptive devices, such as intrauterine devices (IUD's)
- Follow-up care for any problems You may have using birth control methods issued by the family planning providers, including insertion and extraction of IUDs.
- Emergency birth control supplies when filled by a contracting pharmacist, or by a non-contracted provider, in the event of an Emergency.
- Voluntary sterilization services, including tubal ligation (for females) and vasectomies (for males).
- Pregnancy testing and counseling.
- Diagnosis and treatments of sexually transmitted diseases (STDs) if medically indicated.
- Screening, testing and counseling of at-risk individuals for HIV, and Referral for treatment.

Family Planning services, including those of birth control and birth control supplies, are provided at No Cost Share to the Member.

PREGNANCY TERMINATIONS

Molina covers pregnancy termination services subject to certain coverage restrictions required by the Affordable Care Act and by any applicable laws in the State of Washington.

Pregnancy termination services are office-based procedures and do not require Prior Authorization.

If pregnancy termination services will be provided in an inpatient setting or outpatient hospital Prior Authorization is required.

Office Visit and Outpatient Surgery Cost Sharing will apply.

Keep in mind that some hospitals and providers may not provide pregnancy termination services

NUTRITIONAL COUNSELING
We cover Medically Necessary nutritional counseling when necessary to treat medical conditions, and subject to a Referral by Your PCP. Nutritional Counseling is limited to 3 visits per lifetime, Specialty Care or Other Practitioner office visit cost sharing will apply.

PHENYLKETONURIA (PKU) AND OTHER INBORN ERRORS OF METABOLISM
We cover testing and treatment of phenylketonuria (PKU) and other inborn errors of metabolism, including formulas and special food products that are part of a diet prescribed by a physician and managed by a licensed health care professional in consultation with a physician who specializes in the treatment of metabolic disease. The diet must be deemed Medically Necessary to prevent the development of serious physical or mental disabilities or to promote normal development or function.

For purposes of this section, the following definitions apply:

"Formula" is an enteral product for use at home that is prescribed by a physician.

"Special food product" is a food product that is prescribed by a physician for treatment of PKU and other inborn errors of metabolism and used in place of normal food products, such as grocery store foods. It does not include a food that is naturally low in protein.

Other specialized formulas and nutritional supplements are not covered.

Outpatient Professional Services Coinsurance Cost Share will apply.

OUTPATIENT HOSPITAL/FACILITY SERVICES

OUTPATIENT SURGERY
We cover outpatient surgery services provided by Participating Providers if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room. Separate Cost Sharing may apply for Professional services and Facility services.

OUTPATIENT PROCEDURES We cover outpatient care following surgery provided by Participating Providers if a licensed staff member monitors Your vital signs as You regain sensation after receiving drugs to reduce sensation or to minimize discomfort. Separate Cost Sharing may apply for Professional services and Facility services.

SPECIALIZED SCANNING SERVICES
We cover specialized scanning services to include CT Scan, PET Scan and MRI by Participating Providers. Separate Cost Sharing may apply for Professional services and Facility services as shown in the Molina of Washington, Inc. Schedule of Benefits..

RADIOLOGY SERVICES
We cover radiology services, other than specialized scanning services, when furnished by Participating Providers.

LABORATORY SERVICES
We cover the following services when furnished by Participating Providers and Medically Necessary and subject to Cost Sharing:

- Laboratory tests, including Medically Necessary genetic testing
- Other Medically Necessary tests, such as electrocardiograms (EKG) and electroencephalograms (EEG)
- Blood, and blood plasma
- Medically Necessary Genetic Testing (Inclusive of but not limited to, prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures)

MENTAL HEALTH
OUTPATIENT INTENSIVE PSYCHIATRIC TREATMENT PROGRAMS
We cover the following outpatient intensive psychiatric treatment programs at a Participating Provider facility:

- Short-term hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis
- Psychiatric observation for an acute psychiatric crisis

INPATIENT HOSPITAL/FACILITY SERVICES

INPATIENT HOSPITAL SERVICES
You must have a Prior Authorization to get hospital services except in the case of an Emergency or Urgent Care Services. However, if You get services in a hospital or You are admitted to the hospital for Emergency or out-of-area Urgent Care Services, Your hospital stay will be covered. This happens even if You do not have a Prior Authorization.

MEDICAL/SURGICAL SERVICES
We cover the following inpatient services in a Participating Provider hospital or rehabilitation facility, when the services are generally and customarily provided by acute care general hospitals or rehabilitation facilities inside Our Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units

- General and special nursing care
- Operating and recovery rooms
- Services of Participating Provider physicians, including consultation and treatment by Specialist Physicians
- Anesthesia
- Drugs prescribed in accord with Our Drug Formulary guidelines (for discharge drugs prescribed when You are released from the hospital, please refer to "Prescription Drugs and Medications" in this "What is Covered Under My Plan?" section)
- Radioactive materials used for therapeutic purposes
- Durable Medical Equipment and medical supplies
- Imaging, laboratory, and special procedures, including MRI, CT, and PET scans, and ultrasound imaging
- Mastectomies (removal of breast) and lymph node dissections
- Blood, blood products and their administration, blood storage (including the services and supplies of a blood bank).
- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program)
- Respiratory therapy
- Medical social services and discharge planning

Member cost sharing for medical / surgical services including covered prescription drugs, apply to Inpatient Coinsurance Cost Share.

MATERNITY CARE

We cover maternity care services, including complications of pregnancy such as fetal distress, gestational diabetes and toxemia, and services related to labor and delivery:

- Inpatient hospital care for 48 hours after a normal vaginal delivery or 96 hours following a delivery by Cesarean section (C-section). Longer stays need to be Prior Authorized by Molina in consultation with Your physician. (Inpatient Hospital/Facility Services Maternity Cost Sharing will apply.)

- Molina will cover post discharge services and laboratory services, as well as Medically Necessary supplies for home births as discussed under Outpatient Professional Services.

MENTAL HEALTH

INPATIENT PSYCHIATRIC HOSPITALIZATION

We cover inpatient psychiatric hospitalization in a Participating Provider hospital. Coverage includes room and board, drugs, and services of Participating Provider physicians and other Participating Providers who are licensed health care professionals acting within the scope of their license. Involuntary court-ordered inpatient mental health and behavioral health admissions do not require Prior Authorization. Involuntary court-ordered inpatient mental health and behavioral services beyond 72 hours, will be covered only if deemed Medically Necessary by Molina Healthcare's Medical director or designee and available in a Molina participating hospital under the following conditions. We cover inpatient mental and behavioral health services only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, current edition, Text Revision (DSM), including eating disorders associated with a diagnosis of a DSM categorized mental health condition, that results in clinically

significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the DSM identifies as something other than a "mental disorder."

"**Mental Disorders**" include the following conditions:

Severe Mental Illness of a person of any age. "**Severe Mental Illness**" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa.

SUBSTANCE ABUSE DISORDERS
INPATIENT DETOXIFICATION
We cover hospitalization in a Participating Provider hospital only for medical management of withdrawal symptoms, including room and board, Participating Provider physician services, drugs, dependency recovery services, education, and counseling.

SUBSTANCE ABUSE DISORDERS
TRANSITIONAL RESIDENTIAL RECOVERY SERVICES

We cover chemical dependency treatment in a nonmedical transitional residential recovery setting approved in writing by Molina. These settings provide counseling and support services in a structured environment.

SKILLED NURSING FACILITY
We cover skilled nursing facility (SNF) services when Medically Necessary and referred by Your PCP. Covered SNF services include:

- Room and board
- Physician, nursing and Other Practitioner services, including licensed behavioral health providers
- Medications
- Injections

You must have Prior Authorization for these services before the service begins. You will continue to get care without interruption.

The SNF benefit is limited to 60 days per calendar year.

COVERAGE AT A LONG-TERM CARE FACILITY FOLLOWING HOSPITALIZATION

We cover up to 60 days of Medically Necessary care at a Long-Term Care Facility following hospitalization if You resided in that Long-Term Care Facility immediately prior to the hospitalization, and all of the following are met:

Your Primary Care Physician determines that Your medical care needs can be met at the requested Facility

The requested Facility has all applicable licenses and certifications, and is not under a stop placement order that prevents Your readmission

The requested Facility agrees to accept payment for Covered Services at the rate We pay to similar Facilities that are Participating Providers

The requested Facility agrees to abide by the standards, terms, and conditions We require for similar Facilities that are Participating Providers for (i) utilization review, quality assurance, and peer review; and (ii) management and administrative procedures, including data and financial reporting

A "Long-Term Care Facility" or "Facility" for the purpose of this benefit is a nursing facility licensed under Chapter 18.51 of the Revised Code of Washington, a continuing care retirement community defined under Section 70.38.025 of the Revised Code of Washington, or an assisted living facility licensed under Chapter 18.20 of the Revised Code of Washington.

You, or Your authorized representative, must obtain Prior Authorization for these services. Inpatient Hospital/Facility Services Coinsurance cost share will apply.

HOSPICE CARE

If You are terminally ill, We cover these hospice services:

- Home hospice services
- A semi-private room in a hospice facility
- The services of a dietician
- Nursing care
- Medical social services
- Home health aide and homemaker services
- Physician services
- Drugs
- Medical supplies and appliances
- Respite care for up to fourteen days per lifetime. Respite is short-term inpatient care provided in order to give relief to a person caring for You
- Counseling services for You and Your family
- Development of a care plan for You
- Short term inpatient care
- Pain control
- Symptom management

- Physical therapy, occupational therapy, and speech-language therapy, when provided for the purpose of symptom control, or to enable the patient to maintain activities of daily living and basic functional skills.

The hospice benefit is for people who are diagnosed with a terminal illness (life expectancy of twelve (12) months or less). They can choose hospice care instead of the traditional services covered by the plan. Please contact Molina for further information. You must receive Prior Authorization for all inpatient hospice care services.

APPROVED CLINICAL TRIALS

We cover routine patient care costs for qualifying Members participating in approved clinical trials for cancer and/or another life-threatening disease or condition. You will never be enrolled in a clinical trial without Your consent. To qualify for such coverage You must:

- Be enrolled under this Policy
- Be diagnosed with cancer or other life threatening disease or condition
- Be accepted into an approved clinical trial (as defined below)
- Be referred by a Molina doctor who is a Participating Provider
- Received Prior Authorization or approval from Molina

An approved clinical trial means a Phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and (1) the study is approved or funded by one or more of the following: the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, the U.S. Department of Defense, the U.S. Department of Veterans Affairs, or the U.S. Department of Energy, or (2) the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (3) the study or investigation is a drug trial this is exempt from having such an investigational new drug application.

If You qualify, Molina cannot deny Your participation in an approved clinical trial. Molina cannot deny, limit or place conditions on its coverage of Your routine patient costs associated with Your participation in an approved clinical trial for which You qualify. You will not be denied or excluded from any Covered Services under this Policy based on Your health condition or participation in a clinical trial. The cost of medications used in the direct clinical management of the enrollee will be covered unless the clinical trial is for the investigation of that drug or the medication is typically provided free of charge to enrollees in the clinical trial.

Molina does not have an obligation to cover certain items and services which are not routine patient costs, as determined by the Affordable Care Act, even when You incur these costs while in an approved clinical trial. Costs excluded from coverage under Your Policy include:

- The investigational item, device or service itself
- Items and services solely for data collection and analysis purposes and not for direct clinical management of the patient, and
- any service inconsistent with the established standard of care for the patient's diagnosis

RECONSTRUCTIVE SURGERY

We cover the following reconstructive surgery services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Participating Provider physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible
- Following Medically Necessary removal of all or part of a breast, Molina covers reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

For Covered Services related to reconstructive surgery, You will pay the Cost Sharing You would pay if the Covered Services are not related to reconstructive surgery. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital/Facility Services" in the Molina of Washington, Inc. Schedule of Benefits.

RECONSTRUCTIVE SURGERY EXCLUSIONS

The following reconstructive surgery services are not covered:

- Surgery that, in the judgment of a Participating Provider physician specializing in reconstructive surgery, offers only a minimal improvement in appearance
- Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance

TRANSPLANT SERVICES

We cover transplants at participating transplant facilities, of organs, tissue, or bone marrow, or artificial organ transplants based on Molina's medical guidelines and manufacturer's recommendations, if a Participating Provider physician provides a written Referral for care to a transplant facility and Molina authorizes the services, as described in the "Accessing Care" section, under "What is a Prior Authorization?".

After the Referral to a transplant facility, the following applies:

- If either the physician or the referral facility determines that You do not satisfy its respective criteria for a transplant, Molina will only cover services You receive before that determination is made
- Molina is not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with Our guidelines for services for living transplant donors, Molina provides certain donation-related services for a donor, or an individual identified as a potential donor, whether or not the donor is a Member. These services must be directly related to a covered transplant for You, which may include certain services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Our guidelines for donor services are available by calling Our Customer Support Center toll-free at 1 (888) 858-3492.

When medically appropriate, transplant services, supplies and treatment covered under this Policy will also be covered when provided in an outpatient setting.

For covered transplant services, You will pay the Cost Sharing You would pay if the Covered Services are not related to transplant services. For example, for hospital inpatient care, You

would pay the Coinsurance Cost Sharing listed under "Inpatient Hospital/Facility Services" in the Molina of Washington, Inc. Schedule of Benefits.

Molina provides or pays for donation-related services for actual or potential donors (whether or not they are Members) in accord with Our guidelines for donor services at no charge.

PRESCRIPTION DRUG COVERAGE
We cover prescription drugs and medications when:

- They are ordered by a Participating Provider treating You and the drug is listed in the Molina Drug Formulary or has been approved by Molina's Pharmacy Department
- They are ordered or given while You are in an emergency room or hospital
- They are given while You are in a skilled nursing facility and they are ordered by a Participating Provider for a Covered Service and You got the drug or medication through a pharmacy that is in the Molina pharmacy network.
- The drug is prescribed by a Participating Provider who is a family planning doctor or other provider whose services do not require an approval.

Prescription drugs are covered through Molina's contracted pharmacies within Washington. Coverage includes drugs that are self-administered anti-cancer medications at least comparable to cancer chemotherapy medications administered by a health care provider or facility.

Prescription drugs are covered outside of the State of Washington, including when travel takes You outside of the United States (out of area) for Emergency or Urgent Care services only.

If You have trouble getting a prescription filled at the pharmacy, please call Molina's Customer Support Center toll-free at 1 (888) 858-3492 for assistance. If You are deaf or hard of hearing, call us with the National Relay Service by dialing 711.

You may view a list of pharmacies on Molina's website, www.molinahealthcare.com.

Molina Drug Formulary (List of Drugs)
Molina has a list of drugs that it will cover. The list is known as the Drug Formulary. The drugs on the list are chosen by a group of doctors and pharmacists from Molina and the medical community. The group meets every three (3) months to talk about the drugs that are in the formulary. They review new drugs and changes in health care, in order to find the most effective drugs for different conditions. Drugs are added or taken off the Drug Formulary based on changes in medical practice, medical technology, and when new drugs come on the market.

You can look at Our Drug Formulary on Our Molina website at www.molinahealthcare.com. You may call Molina and ask about a drug. Call toll free 1 (888) 858-3492, Monday through Friday, 8:00 a.m. through 5:00 p.m. PT. If You are deaf or hard of hearing, call us with the National Relay Service by dialing 711. You can also ask us to mail You a copy of the Drug Formulary. Remember that just because a drug is on the Drug Formulary does not guarantee that Your doctor will prescribe it for Your particular medical condition.

Access to Drugs Which Are Not Covered
Molina does have a process to allow You to request and gain access to clinically appropriate

drugs that are not covered under Your Policy. If Your doctor orders a drug that is not listed in the Drug Formulary that he or she feels is best for You, Your doctor may make a request that Molina cover the drug for You through Molina's Pharmacy Department. If the request is approved, Molina will contact Your doctor. If the request is denied, Molina will send a letter to You and Your doctor stating why the drug was denied.

If You are taking a drug that is no longer on Our Drug Formulary, Your doctor can ask us to keep covering it by sending us a Prior Authorization request for the drug. The drug must be safe and effective for Your medical condition. Your doctor must write Your prescription for the usual amount of the drug for You**.**

Cost Sharing for Prescription Drugs and Medications
The Cost Sharing for prescription drugs and medications is listed on the Molina of Washington, Inc. Schedule of Benefits. Cost Sharing applies to all drugs and medicines within the Molina Drug Formulary prescribed by a Participating Provider on an outpatient basis unless such drug therapy is an item of EHB preventive care administered or prescribed by a Participating Provider and, therefore, not subject to Cost Sharing.

Formulary Generic Drugs
Formulary Generic drugs are those drugs listed in the Molina Drug Formulary which have the same ingredients as brand name drugs. To be FDA (government) approved the generic drug must have the same active ingredient, strength and dosage (formulation) as the brand name drug. Companies making a generic drug have to prove to the FDA that the drug works just as well and is as safe as the brand name drug. Cost Sharing for Formulary Generic drugs are listed on the Molina of Washington, Inc. Schedule of Benefits. You will be charged a Copayment for Formulary Generic Drugs. If Your doctor orders a brand name drug and there is a Formulary Generic drug available, We will cover the generic medication.

If Your doctor says that You must have the brand name drug instead of the generic, he/she must submit a Prior Authorization request to Molina's Pharmacy department.

Formulary Preferred Brand Name Drugs
Formulary Preferred Brand Name drugs are those drugs listed which, due to clinical effectiveness and cost differences, are designated as "Preferred" in the Molina Drug Formulary. Formulary Preferred Brand Name drugs are prescription drugs or medicines that have been registered under a brand or trade name by their manufacturer and are advertised and sold under that name, and indicated as a brand in the Medi-Span or similar third party national database used by Molina and Our pharmacy benefit manager. Cost Sharing for Formulary Preferred Brand Name drugs are listed on the Molina of Washington, Inc. Schedule of Benefits. Formulary Preferred Brand Name drugs have Copayment Cost Sharing to You.

Formulary Non-Preferred Brand Name Drugs
Formulary Non-Preferred Brand Name drugs are those drugs listed in the Molina Drug Formulary which are designated as "Non-Preferred" due to lesser clinical effectiveness and cost differences. Formulary Non-Preferred Brand Name drugs are prescription drugs or medicines that have been registered under a brand or trade name by their manufacturer and are advertised and sold under that name, and indicated as a brand in the Medi-Span or similar third party national database used by Molina and Our pharmacy benefit manager. Cost Sharing for Formulary Non-Preferred Brand Name drugs are listed on the Molina of Washington, Inc. Schedule of Benefits. You will be

charged Plan Coinsurance after applicable Prescription Drug Deductible for Formulary Non-Preferred Brand Name Drugs

Specialty Oral and Injectable Drugs
Specialty drugs are prescription legend drugs within the Molina Drug Formulary which:

- Are only approved to treat limited patient populations, indications or conditions; or
- Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- Have limited availability, special dispensing, handling and delivery requirements, and/or require additional patient support, any or all of which make the drug difficult to obtain through traditional pharmacies.

Molina may require that Specialty drugs be obtained from a participating specialty pharmacy or facility for coverage. Molina's specialty pharmacy will coordinate with You or Your physician to provide delivery to either Your home or Your provider's office. Coverage includes a limit of three teaching doses of injectable medications per medication, per lifetime, when provided within a Physician Office Visit. For all other Specialty Oral and Injectable Drugs, You will be charged Plan Coinsurance after applicable Prescription Drug Deductible for Specialty Oral and Injectable Drugs

Stop-Smoking Drugs
Stop-Smoking drugs are prescription drugs within the Molina Drug Formulary that We cover to help You stop smoking. You can learn more about Your choices by calling Molina's Health Education Department toll-free at 1 (866) 472-9483, Monday through Friday. Your PCP helps You decide which stop-smoking drug is best for You. You can get up to a three-month supply of stop smoking medication.

Diabetic Supplies
Diabetic supplies, such as insulin, syringes, lancets and lancet puncture devices, blood glucose monitors, , glucagon emergency kits, blood glucose test strips and urine test strips are covered supplies and are provided at Coinsurance to You. Pen delivery systems for the administration of insulin are also covered and are provided at the Preferred Brand cost share.

Day Supply Limit
The prescribing Participating Provider determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, the Participating Provider determines the amount of an item that constitutes a Medically Necessary 30-day supply for You. Upon payment of the Cost Sharing specified in this "Prescription Drug Coverage" section, You will receive the supply prescribed up to a 30-day supply in a 30-day period. Quantities that exceed the day supply limit are not covered unless Prior Authorized.

ANCILLARY SERVICES

DURABLE MEDICAL EQUIPMENT

If You need Durable Medical Equipment, Molina will rent or purchase the equipment for You. Prior Authorization (approval) from Molina is required for Durable Medical Equipment. The equipment must be provided through a vendor that is contracted with Molina. When Prior Authorized, Durable Medical Equipment will be covered for use on either an inpatient or outpatient basis. We cover sales tax, reasonable repairs, maintenance, delivery and related

supplies for Durable Medical Equipment. You may be responsible for repairs to Durable Medical Equipment if they are due to misuse or loss.

Covered Durable Medical Equipment includes (but is not limited to):

- Oxygen and oxygen equipment
- Apnea monitors
- Pulmoaides and related supplies
- Nebulizer machines, face masks, tubing, peak flow meters and related supplies
- Spacer devices for metered dose inhalers
- Colostomy bags, urinary catheters and supplies.

In addition, We cover the following Durable Medical Equipment and supplies for the treatment of diabetes, when Medically Necessary:

- Blood glucose monitors designed to assist Members with low vision or who are blind
- Insulin pumps and all related necessary supplies
- Podiatric devices to prevent or treat diabetes related foot problems
- Visual aids, excluding eye wear, to assist those with low vision with the proper dosing of insulin.

Prosthetic and Orthotic Devices
We do not cover most prosthetic and orthotic devices, but We do cover internally implanted devices and external devices as described in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets Your medical needs
- You receive the device from the provider or vendor that Molina selects

When We do cover a prosthetic and orthotic device, the coverage includes fitting and adjustment of the device, repair or replacement of the device (unless due to loss or misuse), and services to determine whether You need a prosthetic or orthotic device. If We cover a replacement device, then You pay the Cost Sharing that would apply for obtaining that device, as specified below.

Internally implanted devices
We cover prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints if these devices are implanted during a surgery that is otherwise covered by us.

For internally implanted devices, Inpatient Hospital /Facility Services Cost Sharing or Outpatient Hospital/Facility Services Cost Sharing will apply, as applicable.

External devices
We cover the following external prosthetic and orthotic devices:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres required to hold a prosthesis every 12 months
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Participating Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect
- Braces, splints, prostheses, orthopedic appliances and orthotic devices and supplies or apparatuses used to support or align or correct deformities or to improve the function of moving parts

For external devices, Durable Medical Equipment Coinsurance Cost Sharing will apply.

HOME HEALTHCARE
We cover these home health care services when Medically Necessary, referred by Your PCP, and approved by Molina:

- Part-time skilled nursing services
- Nurse visits
- In-home medical care services
- Physical therapy, occupational therapy, or speech therapy
- Medical social services
- Home health aide services
- Medical supplies
- Necessary medical appliances

The following home health care services are covered under Your Policy:

- Up to two hours per visit for visits by a nurse, medical social worker, physical, occupational, or speech therapist and up to four hours per visit by a home health aide
- Up to 130 visits per calendar year (counting all home health visits)

You must have approval for all home health services before the service begins.

Please refer to the “Exclusions” section of this Policy for a description of benefit limitations and applicable exceptions.

TRANSPORTATION SERVICES

Emergency Medical Transportation
We cover Emergency transportation (ambulance), or ambulance transport services provided through the “911” emergency response system when Medically Necessary.

Non-Emergency Medical Transportation
We cover non-Emergency medical transportation to medical facilities when Your medical and physical condition does not allow You to take regular means of public or private transportation (car, bus, air, etc.). This requires that You also have a written prescription from Your doctor. Examples of non-Emergency medical transportation include, but are not limited to, litter vans and wheelchair accessible vans. You must have Prior Authorization from Molina for these services before the services are given.

Non-Emergency Non-Medical Transportation
Non-Emergency non-medical transportation is available if You are recovering from serious injury or medical procedure that prevents You from driving to a medical appointment. You must have no other form of transportation available. Your physician (PCP or Specialist Physician) confirms that You require non-Emergency non-medical transportation to and from an appointment on a specified date.

Non-Emergency non-medical transportation for Members to medical services can be supplied by a passenger car, taxi cabs, or other forms of public/private transportation. Call at least two to three working days before Your appointment to arrange this transportation.

If You need non-Emergency non-medical transportation, please call Your PCP or Molina's Customer Support Center to see if You qualify for these services. You must have Prior Authorization to get these services before the services are given. Please review the Molina of Washington, Inc. Schedule of Benefits to determine applicability of this benefit to You.

HEARING SERVICES
We do not cover hearing aids (other than internally-implanted devices as described in the "Prosthetic and Orthotic Devices" section).

We do cover routine hearing screenings that are Preventive Care Services at no charge

OTHER SERVICES

DIALYSIS SERVICES
We cover acute and chronic dialysis services if all of the following requirements are met:

- The services are provided inside Our Service Area
- You satisfy all medical criteria developed by Molina
- A Participating Provider physician provides a written Referral for inpatient or outpatient care at a facility or at home

EXCLUSIONS

What is Excluded from Coverage Under My Plan?
This "Exclusions" section lists items and services excluded from coverage under this Policy. These exclusions apply to all services that would otherwise be covered under this Policy regardless of whether the services are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "What is Covered Under My Plan?" section.

Artificial Insemination and Conception by Artificial Means
All services related to artificial insemination and conception by artificial means, such as: ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

Certain Exams and Services
Physical exams and other services:

- Required for obtaining or maintaining employment or participation in employee programs,
- Required for insurance or licensing, or
- On court order or required for parole or probation. This exclusion does not apply if a Participating Provider physician determines that the services are Medically Necessary

Cosmetic Services
Services that are intended primarily to change or maintain Your appearance, except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "What is Covered Under My Plan?" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "What is Covered Under My Plan?" section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after a mastectomy, and prostheses to replace all or part of an external facial body part

Custodial Care
Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care.

Dental and Orthodontic Services
Dental and orthodontic services such as x-rays, appliances, implants, services provided by dentists or orthodontists, dental services following accidental injury to teeth, and dental services resulting from medical treatment such as surgery on the jawbone and radiation treatment.

This exclusion does not apply to services covered under "Dental and Orthodontic Services" in the "What is Covered Under My Plan?" section.

Disposable Supplies
Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies. This exclusion does not apply to disposable supplies that are listed as covered in the "What is Covered Under My Plan?" section.

Experimental or Investigational Services
Any medical service including procedures, medications, facilities, and devices that Molina has

determined have not been demonstrated as safe or effective compared with conventional medical services. In determining whether services are Experimental or Investigational, Molina will consider whether the services are in general use in the medical community in the State of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious.

This exclusion does not apply to any of the following:

- Services covered under "Approved Clinical Trials" in the "What is Covered Under My Plan?" section

Please refer to the "External Review or Appeal" section for information about External Review or Appeal related to denied requests for Experimental or Investigational services.

Hair loss or growth treatment
Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Infertility Services
Services related to the treatment of infertility, but diagnostic procedures are covered.

Intermediate Care
Care in a licensed intermediate care facility. This exclusion does not apply to services covered under "Durable Medical Equipment," "Home Health Care," "Skilled Nursing Facility Care" and "Hospice Care" in the "What is Covered Under My Plan?" section.

Intermediate Care facility (ICF)
A health related facility designed to provide custodial care for individuals unable to care for themselves because of mental or physical infirmity, but without the degree of care provided by a hospital or skilled nursing facility.

Items and Services That are Not Health Care Items and Services
Molina does not cover services that are not health care services, for example:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services that increase academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching You how to read, whether or not You have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy

Items and Services to Correct Refractive Defects of the Eye
Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism, except those Covered Services listed under "Pediatric Vision Services" in the "What is Covered Under My Plan" section.

Oral Nutrition
Outpatient oral nutrition, such as dietary or nutritional supplements, specialized formulas, supplements, herbal supplements, weight loss aids, formulas, and food.

This exclusion does not apply to any of the following:

- Formulas and special food products when prescribed for the treatment of Phenylketonuria and other inborn errors of metabolism, in accordance with the "Phenylketonuria (PKU)" section of this Policy.

Private Duty Nursing
Private duty nursing services are not covered.

Residential Care
Care in a facility where You stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a skilled nursing facility, inpatient respite care covered in the "Hospice Care" section, a licensed facility providing crisis residential services covered under "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in the "Mental Health Services" section, or a licensed facility providing transitional residential recovery services covered under the "Substance Abuse Disorder Services" section.

Routine Foot Care Items and Services
Routine foot care items and services that are not Medically Necessary.

Services Not Approved by the Federal Food and Drug Administration
Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion applies to services provided anywhere, even outside the U.S.

This exclusion does not apply to services covered under "Approved Clinical Trials" in the "What is Covered Under My Plan" section.

Please refer to the "External Review or Appeal for Denials of Experimental/Investigational Therapies" section for information about External Review or Appeal related to denied requests for Experimental or Investigational services.

Services Performed by Unlicensed People
Except as otherwise provided in this Policy, services that are performed by people who do not require licenses or certificates by the state to provide health care services are not covered.
Services Related to a Non-Covered Service
When a Service is not covered, all services related to the non-Covered Service are excluded, except for services Molina would otherwise cover to treat complications of the non-Covered

Service. For example, if You have a non-covered cosmetic surgery, Molina would not cover services You receive in preparation for the surgery or for follow-up care. If You later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and Molina would cover any services that Molina would otherwise cover to treat that complication.

Surrogacy
Services for anyone in connection with a surrogacy arrangement, except for otherwise-Covered Services provided to a Member who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Travel and Lodging Expenses
Travel and lodging expenses are not covered.

THIRD-PARTY LIABILITY

You agree that, if Covered Services are provided to treat an injury or illness caused by the wrongful act or omission of another person or third party, provided that You are made whole for all other damages resulting from the wrongful act or omission before Molina is entitled to reimbursement, then You shall:

- Reimburse Molina for the reasonable cost of services paid by Molina to the extent permitted by Washington immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise; and
- Fully cooperate with Molina's effectuation of its lien rights for the reasonable value of services provided by Molina to the extent permitted under Washington law. Molina's lien may be filed with the person whose act caused the injuries, his or her agent or the court.

Molina shall be entitled to payment, reimbursement, and subrogation (recover benefits paid when other insurance provides coverage) in third party recoveries and You shall cooperate to fully and completely assist in protecting the rights of Molina including providing prompt notification of a case involving possible recovery from a third party.

WORKERS' COMPENSATION

Molina shall not furnish benefits under this Agreement which duplicate the benefits to which You are entitled under any applicable workers' compensation law. You are responsible for taking whatever action is necessary to obtain payment under workers' compensation laws where payment under the workers compensation system can be reasonably expected. Failure to take proper and timely action will preclude Molina's responsibility to furnish benefits to the extent that payment could have been reasonably expected under workers' compensation laws. If a dispute arises between You and the Workers' Compensation carrier, as to Your ability to collect under workers' compensation laws, Molina will provide the benefits described in this Agreement until resolution of the dispute.

If Molina provides benefits which duplicate the benefits You are entitled to under workers' compensation law, Molina shall be entitled to reimbursement for the reasonable cost of such benefits.

RENEWAL AND TERMINATION

How Does my Molina Coverage Renew?
Coverage shall be renewed on the first day of each month, upon Molina's receipt of any prepaid Premiums due. Renewal is subject to Molina's right to amend this Policy. You must follow the procedures required by the Health Benefit Exchange to re-determine Your eligibility for enrollment every year during the Health Benefit Exchange's annual open enrollment period.

Changes in Premiums, Deductibles, Copayments and Benefits and Coverage:
Any change to this Agreement, including changes in Premiums, Benefits and Coverage or Covered Services, Deductible, Copayment, Coinsurance and Annual Out-of-Pocket Maximum amounts, is effective after 60 days' notice to the Subscriber's address of record with Molina.

When Will My Molina Membership End?
(Termination of Benefits and Coverage)
The termination date of Your coverage is the first day You are not covered with Molina (for example, if Your termination date is July 1, 2015, Your last minute of coverage was at 11:59 p.m. on June 30, 2015). If Your coverage terminates for any reason, You must pay all amounts payable and owing related to Your coverage with Molina, including Premiums, for the period prior to Your termination date.

Except in the case of fraud or deception in the use of services or facilities, Molina will return to You within 30 days the amount of Premiums paid to Molina which corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any, less any amounts due Molina.

Your membership with Molina will terminate if You:

- **No Longer Meet Eligibility Requirements:** You no longer meet the age or other eligibility requirements for coverage under this Policy as required by Molina or the Health Benefit Exchange. You no longer live or work in Molina's Service Area for this Policy. The Health Benefit Exchange will send You notice of any eligibility determination. Molina will send You notice when it learns You have moved out of the Service Area. Coverage will end at 11:59 p.m. on the last day of the month following the month in which either of these notices is sent to You unless You request an earlier termination effective date.

- **Request Disenrollment:** You decide to end Your membership and disenroll from Molina by notifying Molina or the Health Benefit Exchange. Your membership will end at 11:59 p.m. on the 14th day following the date of Your request or a later date if requested by You. Molina may, at its discretion, accommodate a request to end Your membership in fewer than 14 days.

- **Have Child-Only Coverage:** Child-Only Coverage under this Policy, including coverage of dependents of Child-Only Coverage members, will terminate at 11:59 p.m. on the last day of the month in which the non-Dependent Member reaches age 21. When Child-Only Coverage under this Policy terminates because the Member has reached age 21, the Member and any Dependents may be eligible to enroll in other products offered by Molina through the Health Benefit Exchange.

- **Change Health Benefit Exchange Health Plans**: You decide to change from Molina to another health plan offered through the Health Benefit Exchange during an annual open enrollment period or other special enrollment period for which You have been determined eligible in accordance with the Health Benefit Exchange's special enrollment procedures, or when You seek to enroll a new Dependent. Your membership will end at 11:59 p.m. on the day before the effective date of coverage through Your new health plan.

- **Fraud or Misrepresentation:** You commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of Your coverage with Molina. A notice of termination will be sent, Your membership will end at 11:59 p.m. on the seventh day from the date the notice of termination is mailed. Some examples include:

    - Misrepresenting eligibility information.
    - Presenting an invalid prescription or physician order.
    - Misusing a Molina Member ID Card (or letting someone else use it).

After Your first 24 months of coverage, Molina may not terminate Your coverage due to any omissions, misrepresentations or inaccuracies in Your application form (whether willful or not).

If Molina terminates Your membership for cause, You will not be allowed to enroll with us in the future. We may also report criminal fraud and other illegal acts to the appropriate authorities for prosecution.

- **Discontinuation:** If Molina ceases to provide or arrange for the provision of health benefits for new or existing health care service plan policies, in which case Molina will provide You with written notice at least 180 days prior to discontinuation of those policies.

- **Withdrawal of Plan:** Molina withdraws this Policy from the market, in which case Molina will provide You with written notice at least 90 days before the termination date.

- **Nonpayment of Premiums:** If You do not pay required Premiums by the due date, Molina may terminate Your coverage as further described below.

Your coverage under certain Benefits and Coverage will terminate if Your eligibility for such benefits end. For instance, a Member who attains the age of 19 will no longer be eligible for Pediatric Vision Services covered under this Agreement and, as a result, such Member's coverage under those specific Benefits and Coverage will terminate on his or her 19th birthday, without affecting the remainder of this Policy. Any Dependent Member who no longer is eligible to remain on the coverage by reason of termination of marriage or death of the principle Subscriber, shall have the right to continue this Policy without any proof of insurability. Please contact the Molina Customer Support Center at 1 (888) 858-3492 or dial 711 for the National Relay Service for the deaf or hard of hearing for assistance in transferring Your coverage.

PREMIUM PAYMENTS AND TERMINATION FOR NON-PAYMENT

Premium Notices/Termination for Non-Payment of Premiums. Your Premium payment obligations are as follows:

Your Premium payment for the upcoming coverage month is due no later than the 23rd day of the prior month. This is the "**Due Date.**" The Health Benefit Exchange will send You a bill in advance of the Due Date for the upcoming coverage month. If the full Premium payment is not received on or before the Due Date, the Health Benefit Exchange will send a notice of non-receipt of Premium payment and delinquency notice (the "**Late Notice**") to the Subscriber's address of record. This Late Notice will include, among other information, the following:

- A statement that Molina has not received full Premium payment and that We will terminate this Agreement for nonpayment if the required Premiums are not paid prior to the expiration of the grace period as described in the Late Notice.
- The amount of Premiums due.
- The specific date and time when the membership of the Subscriber and any enrolled Dependents will end if the required Premiums are not paid.

If You have received a Late Notice that Your coverage is being terminated or not renewed due to failure to pay Your Premium, Molina will give a:

- 30-day grace period to pay the full Premium payment due if You do not receive advance payment of the premium tax credit; or,
- Three month grace period to pay the full Premium payment due if You receive advance payment of the premium tax credit. Molina will suspend payment for Covered Services received after the first month of the grace period until We receive the delinquent Premiums. If Premiums are not received by the end of the three-month grace period, You will be responsible for payment of the Covered Services received during the second and third months.

During the grace period applicable to You, You can avoid termination or nonrenewal of this Agreement by paying the full Premium payment You owe Molina. <u>If You do not pay the full Premium payment by the end of the grace period, this Agreement will be terminated.</u> You will still be responsible for any unpaid Premiums You owe Molina for the grace period if You receive advance payment of the premium tax credit.

Termination or nonrenewal of this Agreement for non-payment will be effective:

- The last day of the month prior to the beginning of the grace period if You do not receive advance payment of the premium tax credit; or,

- The last day of the first month of the grace period if You receive advance payment of the premium tax credit

Termination Notice: Upon termination of this Agreement, the Health Benefit Exchange will mail a Termination Notice to the Subscriber's address of record specifying the date and time when the membership ended.

YOUR RIGHTS AND RESPONSIBILITIES

What are My Rights and Responsibilities as a Molina Member?

These rights and responsibilities are on the Molina web site: www.molinahealthcare.com.

Your Rights

You have the right to:

- Be treated with respect and recognition of Your dignity by everyone who works with Molina.
- Get information about Molina, Our providers, Our doctors, Our services and Members' rights and responsibilities.
- Choose Your "main" doctor from Molina's list of Participating Providers (This doctor is called Your Primary Care Doctor or Personal Doctor).
- Be informed about Your health. If You have an illness, You have the right to be told about all treatment options regardless of cost or benefit coverage. You have the right to have all Your questions about Your health answered.
- Help make decisions about Your health care. You have the right to refuse medical treatment.
- You have a right to Privacy. We keep Your medical records private.*
- See Your medical record. You also have the right to get a copy of and correct Your medical record where legally allowed.*
- Complain about Molina or Your care. You can call, fax, e-mail or write to Molina's Customer Support Center.
- Appeal Molina's decisions. You have the right to have someone speak for You during Your grievance.
- Disenroll from Molina (leave the Molina Policy).
- Ask for a second opinion about Your health condition.
- Ask for someone outside Molina to look into therapies that are Experimental or Investigational.
- Decide in advance how You want to be cared for in case You have a life-threatening illness or injury.
- Get information about Molina, Your providers, or Your health in the language You prefer.
- Ask for and get materials in other formats such as, larger size print, audio and Braille upon request and in a timely fashion appropriate for the format being requested and in accordance with state laws.

- Get a copy of Molina's list of approved drugs (Drug Formulary) on request.
- Submit a grievance if You do not get Medically Necessary medications after an Emergency visit at one of Molina's contracted hospitals.
- Not to be treated poorly by Molina or Your doctors for acting on any of these rights.
- Make recommendations regarding Molina's Member rights and responsibilities policies.
- Be free from controls or isolation used to pressure, punish or seek revenge.
- File a grievance or complaint if You believe Your linguistic needs were not met by Molina.

*Subject to State and Federal laws

Your Responsibilities
You have the responsibility to:

- Learn and ask questions about Your health benefits. If You have a question about Your benefits, call toll-free at 1-888-858-3492.
- Give information to Your doctor, provider, or Molina that is needed to care for You.
- Be active in decisions about Your health care.
- Follow the care plans for You that You have agreed on with Your doctor(s).
- Build and keep a strong patient-doctor relationship. Cooperate with Your doctor and staff. Keep appointments and be on time. If You are going to be late or cannot keep Your appointment, call Your doctor's office.
- Give Your Molina card when getting medical care. Do not give Your card to others. Let Molina know about any fraud or wrong doing.
- Understand Your health problems and participate in developing mutually agreed-upon treatment goals as You are able.

Be Active In Your Healthcare
Plan Ahead

- Schedule Your appointments at a good time for You
- Ask for Your appointment at a time when the office is least busy if You are worried about waiting too long
- Keep a list of questions You want to ask Your doctor
- Refill Your prescription before You run out of medicine

Make the Most of Doctor Visits

- Ask Your doctor questions
- Ask about possible side effects of any medication prescribed
- Tell Your doctor if You are drinking any teas or taking herbs. Also tell Your doctor about any vitamins or over–the-counter medications You are using

Visiting Your Doctor When You are Sick.

- Try to give Your doctor as much information as You can.

- Are You getting worse or are Your symptoms staying about the same?
- Have You taken anything?

If You would like more information, please call Molina's Customer Support Center toll-free at 1 (888) 858-3492, Monday through Friday, between 8:00 a.m. and 5:00 p.m. PT.

MOLINA HEALTHCARE SERVICES

Molina is Always Improving Services
Molina makes every effort to improve the quality of health care services provided to You. Molina's formal process to make this happen is called the "Quality Improvement Process." Molina does many studies through the year. If We find areas for improvement, We take steps that will result in higher quality care and service.

If You would like to learn more about what We are doing to improve, please call Molina toll-free at 1 (888) 858-3492 for more information.

Your Healthcare Privacy
Your privacy is important to us. We respect and protect Your privacy. Please read Our Notice of Privacy Practices, at the front of this Policy.

New Technology
Molina is always looking for ways to take better care of Our Members. That is why Molina has a process in place that looks at new medical technology, drugs, and devices for possible added benefits. Our Medical Directors find new medical procedures, treatment, drugs and devices when they become available. They present research information to the Utilization Management Committee where physicians review the technology. Then they suggest whether it can be added as a new treatment for Molina Members. For more information on new technology, please call Molina's Customer Support Center.

What Do I Have to Pay For?
Please refer to the "Molina of Washington, Inc. Schedule of Benefits" at the front of this Policy for Your Cost Sharing responsibilities for Covered Services.

Note that You may be liable to pay for the full price of medical services when:

- You ask for and get medical services that are not covered, such as cosmetic surgery.
- Except in the case of Emergency or out of area Urgent Care Services, You ask for and get health care services from a doctor or hospital that is not a Participating Provider with Molina without getting an approval from Your PCP or Molina

If Molina fails to pay a Molina provider (also known as a Participating Provider) for giving You Covered Services, You are not responsible for paying the provider for any amounts owed by us. This is not true for providers who are not contracted with Molina. For information on how to file a grievance if You receive a bill, please see below.

What if I have paid a medical bill or prescription?
(Reimbursement Provisions)
With the exception of any required Cost Sharing amounts (such as a Deductible, Copayment or Coinsurance), if You have paid for a Covered Service or prescription that was approved or does not require approval, Molina will pay You back. You will need to mail or fax us a copy of the bill from the doctor, hospital or pharmacy and a copy of Your receipt. If the bill is for a prescription, You will need to include a copy of the prescription label. Mail this information to Molina's Customer Support Center. The address is on page 7 of this Policy.

After We receive Your letter, We will respond to You within 30 days. If Your claim is accepted, We will mail You a check. If not, We will send You a letter telling You why. If You do not agree with this, You may appeal by calling Molina toll-free at 1 (888) 858-3492, Monday through Friday, 8:00 a.m. to 5:00 p.m. PT.

How Does Molina Pay for My Care?
Molina contracts with providers in many ways. Some Molina Participating Providers are paid a flat amount for each month that You are assigned to their care, whether You see the provider or not. There are also some providers who are paid on a fee-for-service basis. This means that they are paid for each procedure they perform. Some providers may be offered incentives for giving quality preventive care. Molina does not provide financial incentives for utilization management decisions that could result in Referral denials or under-utilization. For more information about how providers are paid, please call Molina's Customer Support Center toll-free at 1 (888) 858-3492, Monday through Friday, 8:00 a.m. to 5:00 p.m. PT. You may also call Your provider's office or Your provider's medical group for this information.

COORDINATION OF BENEFITS

This Coordination of Benefits ("**COB**") provision applies when a person has health care coverage under more than one Plan**. Plan** is defined below.
The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the "**Primary Plan**". The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the "**Secondary Plan**". The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense**.**

DEFINITIONS
A "**Plan**" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

(1) **Plan** includes: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care

components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan**.** If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan**.**

"**This Plan**" means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and must make payment in an amount so that, when combined with the amount paid by the Primary Pan, the total benefits paid or provided by all plans for the claim equal 100% of the total Allowable Expense for that claim. This means that when this Plan is secondary, it must pay the amount which, when combined with what the Primary Plan paid, totals 100% of the highest Allowable Expense. In addition, if this plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an allowable expense under This Plan. If This Plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.
"**Allowable Expense**" is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an allowable expense.

The following are examples of expenses that are not Allowable Expenses**:**

- The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense**,** unless one of the Plans provides coverage for private hospital room expenses.
- If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement

methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense**.**

- If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense**.**

"**Closed Panel Plan**" is a Plan that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the Plan**,** and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

"**Custodial Parent**" is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES
When a person is covered by two or more Plans**,** the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan**.**

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the Plan provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a **closed panel plan** to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan**.**

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan**.**

(2) Dependent child covered under more than one Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(b) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan**;** or

(c) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan**.**

(d) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;

(ii) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

(iii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above determine the order of benefits;

(iv) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph (a) above determine the order of benefits; or

(v) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the **custodial parent,** first;
- The Plan covering the spouse of the **custodial parent,** second;
- The Plan covering the **noncustodial parent,** third; and then
- The Plan covering the spouse of the **noncustodial parent,** last

(e) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above

determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan**.** The Plan covering that same person as a retired or laid-off employee is the Secondary Plan**.** The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan**,** the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan**.**

(6) If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Plans meeting the definition of Plan**.** In addition, This Plan will not pay more than it would have paid had it been the Primary Plan**.**

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a claim determination period are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the **secondary plan** must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all Plans for the claim equal one hundred percent of the total Allowable Expense for that claim **total allowable expense** is the highest **Allowable Expense** of the **Primary Plan** or the **secondary plan.** In addition, the **secondary Plan** must credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under This Plan and other Plans. Molina] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Molina any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT
If payments that should have been made under This Plan are made by another Plan, the issuer has the right, at its discretion, to remit to the other Plan the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other Plan are considered benefits paid under This Plan. To the extent of such payments, the issuer is fully discharged from liability under This Plan.

RIGHT OF RECOVERY
The issuer has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

Coordination Disputes
If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. Follow the steps described in the "Complaints" section, below. If you are still not satisfied, you may call the Washington State Office of the Insurance Commissioner for instructions on filing a consumer complaint. Call 1- 800-562-6900 or 1- 360-725-7080, or visit Washington State Office of the Insurance Commissioner website at www.insurance.wa.gov.

Advance Directives
An Advance Directive is a form that tells medical providers what kind of care You want if You cannot speak for Yourself. An Advance Directive is written before You have an Emergency. This is a way to keep other people from making important health decisions for You if You are not well enough to make Your own. A “Durable Power of Attorney for Health Care” or “Natural Death Act Declaration” are types of Advance Directives. You have the right to complete an Advance Directive. Your PCP can answer questions about Advance Directives. You may call Molina to get information regarding State law on Advance Directives, and changes to Advance Directive laws. Molina updates advanced directive information no later than ninety (90) calendar days after receiving notice of changes to State laws. For more information, call Molina’s Customer Support Center toll-free at 1 (888) 858-3492. If You are deaf or hard of hearing, dial 711 for the National Relay Service.

Grievances and Appeals

Definitions Used in Grievances and Appeals
“Adverse Benefit Determination” means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member’s or applicant's eligibility to participate in this plan, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

"External Review or Appeal" means a request by a Member or the Member's designated representative for an Independent Review Organization to determine whether Molina's Internal Review decisions are correct.

"Final External Review Decision" means a determination by an Independent Review Organization at the conclusion of an External Review or Appeal.

"Final Internal Adverse Benefit Determination" means an Adverse Benefit Determination that has been upheld by Molina at the completion of the Internal Review or Appeal process, or an Adverse Benefit Determination for which the Internal Review or Appeal process has been exhausted.

"Grievance" means a verbal or written complaint submitted by or on behalf of a Member regarding service delivery issues other than denial of payment for or non-provision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or dissatisfaction with the service provided by Molina.

"Independent Review Organization" means a certified independent review organization established by the Washington State Insurance Commissioner that is not affiliated with Molina.
"Internal Review or Appeal" means the request by or on behalf of a Member to review and reconsider an Adverse Benefit Determination.

What if I Have a Complaint (Grievance)?
If You have a problem with any Molina services, We want to help.
Molina recognizes the fact that Members may not always be satisfied with the care and services provided by Our contracted doctors, hospitals and other providers. We want to know about Your problems and complaints. You may file a Grievance (also called a complaint) in person, in writing, or by telephone. You must file Your Grievance within one hundred eighty (180) days from the day the incident or action occurred which caused You to be unhappy.

You or a person designated by You to assist can contact us by telephone or in writing at:

- Call Molina toll-free at 1 (888) 858-3492, Monday through Friday, 8:00 a.m. - 5:00 p.m. PT. Deaf or hard of hearing Members may dial 711 for the National Relay Service. If You need assistance to file a Grievance in a language other than English or need an accessible format, Our Customer Support Center can make arrangements for translation or interpreter assistance.

- You may also send us Your Grievance in writing by mail or by filing online at Our website. Our address is:

  Molina
  Grievance and Appeals Unit
  P.O. Box 4004
  Bothell, WA 98041

  www.molinahealthcare.com

We will send You a letter acknowledging receipt of Your Grievance within 72 hours of Our receipt of the request. Grievances will be resolved within thirty (30) calendar days. Appeals of Adverse Benefit Determinations will be resolved as noted below.

Appeals

When You receive an Adverse Benefit Determination, You can file an appeal with Molina.

There are two levels of appeals, an Internal Review or Appeal and an External Review or Appeal. When the Internal Review or Appeal is final, You may request an External Review or Appeal of the Final Internal Adverse Benefit Determination as explained below.

INTERNAL REVIEW OR APPEAL

Requests for Internal Review or Appeal of Adverse Benefit Determinations must be received within 180 days of Your receipt of an Adverse Benefit Determination. Requests for Internal Review or Appeals may be made by calling Molina at 888-858-3492 between 8:00 a.m. to 5:00 p.m. PT Monday through Friday, or in writing and sent to the following mailing address or electronic mail address:

Molina
Grievance and Appeals Unit
P.O. Box 4004
Bothell, WA 98041

www.molinahealthcare.com

We will send You a letter acknowledging receipt of Your request for Internal Review or Appeal within 72 hours of Our receipt of the request. Molina's Internal Review or Appeal procedures will be completed within fourteen (14) calendar days for Adverse Benefit Determinations and twenty (20) calendar days for appeals involving Experimental and Investigational procedures. We may extend the time it takes to make a decision by up to 16 additional days if We notify You of the extension and the reason for the extension. Any further extensions by us are subject to Your informed written consent to an extension. An extension will not extend the time for a determination beyond thirty (30) calendar days without Your written consent.

You may submit information, comments, records and other items to assist in the review. You may review and copy Our records and information relevant to the claim free of charge. We will consider all information submitted prior to making Our determination. Our review panel will be performed by persons who were not involved in the original decision and who are not subordinates of the persons who made the original decision.

If You are receiving services that are the subject of an Internal Review or Appeal, those services will be continued until the Internal Review or Appeal is resolved if You request the continuation. However, if Molina prevails on final determination of the Internal Review or Appeal, You may be responsible for the cost of the coverage received during the review period.

After the Internal Review or Appeal is complete, We will send You a written decision on Your appeal determination and will provide information about what We considered, including the clinical basis for Our determination and how You can obtain the clinical review criteria used to

help make the decision. If applicable, We will also provide You with information for obtaining an External Review or Appeal of a Final Internal Adverse Benefit Determination.

EXPEDITED REVIEW

You may request an expedited Internal Review or Appeal of an Adverse Benefit Determination if one of the following conditions apply:

- You are currently receiving or have been prescribed treatment or benefits that would end because of the Adverse Determination.
- If Your provider believes that a delay in treatment based on the standard review time may seriously jeopardize Your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain.
- If the Adverse Determination is related to an admission, availability of care, continued stay, or emergency health care services and You have not been discharged from the emergency room or transport service.

Requests for expedited Internal Reviews or Appeals may be made in writing or by telephone. You, a person designated by You to assist, or Your provider may contact us by telephone or in writing at:

- Call Molina toll-free at 1 (888) 858-3492, Monday through Friday, 8:00 a.m. - 5:00 p.m. PT. Deaf or hard of hearing Members may dial 711 for the National Relay Service.

- Molina
  Grievance and Appeals Unit
  P.O. Box 4004
  Bothell, WA 98041

  www.molinahealthcare.com

Formal responses to an expedited Internal Review or Appeal will be issued no later than 72 hours after Your initial contact with us.

You may also request a concurrent expedited review of an Adverse Benefit Determination, which means that the Internal Review or Appeal and the External Review or Appeal are handled at the same time. Concurrent expedited reviews are available if one of the following conditions applies:

- You are currently receiving or have been prescribed treatment or benefits that would end because of the Adverse Determination.
- If Your provider believes that a delay in treatment based on the standard review time may seriously jeopardize Your life, overall health or ability to regain maximum function, or would subject You to severe and intolerable pain.
- If the Adverse Determination is related to an admission, availability of care, continued stay, or emergency health care services and You have not been discharged from the emergency room or transport service.

Requests for concurrent expedited review may be made in writing or by telephone. You, a person designated by You to assist, or Your provider may contact us by telephone or in writing at:

- Call Molina toll-free at 1 (888) 858-3492, Monday through Friday, 8:00 a.m. - 5:00 p.m. PT. Deaf or hard of hearing Members may dial 711 for the National Relay Service.
- Molina
  Grievance and Appeals Unit
  P.O. Box 4004
  Bothell, WA 98041

  www.molinahealthcare.com

Molina will issue a formal response no later than 72 hours after Your initial contact with us. Please see below for more information on External Review or Appeals.

EXTERNAL REVIEW OR APPEAL

Within 180 days after You have received Our Final Internal Adverse Benefit Determination, or if We have not responded to Your request for an Internal Review or Appeal within the time periods noted above, You may request an External Review or Appeal from an Independent Review Organization ("IRO"). Requests for External Review or Appeals must be in writing and sent to the following mailing address or electronic mail address:

Molina
Grievance and Appeals Unit
P.O. Box 4004
Bothell, WA 98041

www.molinahealthcare.com

Upon receipt of a valid request for an External Review or Appeal, Molina will arrange for the review from an Independent Review Organization (IRO) at no cost to You, and will provide You with the IRO contact information within 24 hours of selecting the IRO. The IRO is unbiased and not controlled by Us. We will provide the IRO with the appeal documentation, but You may also provide them with information.

The IRO process is optional and You pay no application or processing fees of any kind. You have the right to give information in support of Your request and have 5 business days from the request for an External Review or Appeal to submit any supporting written information to the IRO. If You are receiving services that are the subject of the appeal, those services will be continued until the matter is resolved by the IRO if You request the continuation. If Our Adverse Benefit Determination is upheld by the IRO, You may be responsible for paying for any services that have been continued during the External Review or Appeal.

The dispute will be submitted to the IRO's medical reviewers who will make an independent determination of whether or not the care is Medically Necessary or appropriate and the application of this Policy's coverage provisions to Your health care services. You will get a copy of the IRO's Final External Review Decision. If the IRO determines the service is Medically Necessary or appropriate for coverage under the Policy, Molina will provide the health care service.

If Your case involves Experimental or Investigational treatment, the IRO will ensure that adequate clinical and scientific experience and protocols are taken into account.

For non-urgent cases, the IRO must provide its determination within the earlier of fifteen (15) days after the IRO receives the necessary information or twenty (20) days of receipt of Your request.

You may request an expedited External Review or Appeal if one of the following conditions apply:

- You receive a Final Adverse Benefit Determination concerning an admission, availability of care, continued stay, or health care service for which You received emergency services and have not been discharged from the facility.
- You receive a Final Adverse Benefit Determination involving a medical condition for which the standard external review time would seriously jeopardize Your life or health or jeopardize Your ability to regain maximum function.
- Your request for a concurrent expedited review is granted.

If the External Review or Appeal is expedited, the IRO must notify You within 72 hours of its Final External Review Decision. If the notice is not in writing, the IRO must provide You with written confirmation of its Final External Review Decision within 48 hours after the date of the decision.

For more information regarding the External Review or Appeal process, or to request an appeal, please call Molina toll-free at 1 (888) 858-3492. If You are deaf or hard of hearing, dial 711 for the National Relay Service.

Washington State Office of the Insurance Commissioner

If You have any questions or complaints regarding Our handling of Your Grievance or appeal, You may contact the Washington State Office of the Insurance Commissioner. A Washington State Office of the Insurance Commissioner representative will review Your issues, and if the representative can't help you, he or she will point you in the right direction for further assistance.

Washington State Office of the Insurance Commissioner
Call 800-562-6900 or
Call 360-725-7080
TDD 360-586-0241
Fax to 360-586-2018
Email CAP@oic.wa.gov

OTHER

MISCELLANEOUS PROVISIONS

Acts Beyond Molina's Control

If circumstances beyond the reasonable control of Molina, including any major disaster, epidemic, complete or partial destruction of facility, war, riot, or civil insurrection, result in the unavailability of any facilities, personnel, or Participating Providers, then Molina and the Participating Provider shall provide or attempt to provide Benefits and Coverage insofar as practical, according to their best judgment, within the limitation of such facilities and personnel and Participating Providers. Neither Molina nor any Participating Provider shall have any

liability or obligation for delay or failure to provide Benefits and Coverage if such delay or failure is the result of any of the circumstances described above.

Waiver
Molina's failure to enforce any provision of this Agreement shall not be construed as a waiver of that provision or any other provision of this Agreement, or impair Molina's right to require Your performance of any provision of this Agreement.

Non-Discrimination
Molina does not discriminate in hiring staff or providing medical care on the basis of pre-existing health condition, color, creed, age, national origin, ethnic group identification, religion, handicap, disability, sex or sexual orientation.

If You think You have not been treated fairly please call the Customer Support Center toll-free at 1(888) 858-3492.

Organ or Tissue Donation
You can become an organ or tissue donor. Medical advancements in organ transplant technology have helped many patients. However, the number of organs available is much smaller than the number of patients in need of an organ transplant. You may choose to be an organ tissue donor by registering with the Washington Department of Licensing when You apply for or renew Your Driver's License or by going online at www.donatelifetoday.org to add Your name to the registry.

Agreement Binding on Members
By electing coverage or accepting benefits under this Agreement, all Members legally capable of contracting, and the legal representatives for all Members incapable of contracting, agree to all provisions of this Agreement.

Assignment
You may not assign this Agreement or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Our prior written consent.

Governing Law
Except as preempted by federal law, this Agreement will be governed in accordance with Washington law and any provision that is required to be in this Agreement by state or federal law shall bind Molina and Members whether or not set forth in this Agreement.

Invalidity
If any provision of this Agreement is held illegal, invalid or unenforceable in a judicial proceeding or binding arbitration, such provision shall be severed and shall be inoperative, and the remainder of this Agreement shall remain operative and in full force and effect.

Notices
Any notices required by Molina under this Agreement will be sent to the most recent address We have for the Subscriber. The Subscriber is responsible for notifying us of any change in address.

HEALTH EDUCATION AND HEALTH MANAGEMENT SERVICES

The tools and services described here are educational support for Our Members. We may change them at any time as necessary to meet the needs of Our Members.

Health Management

Molina offers many tools to help keep You and Your family healthy. You may ask for brochures on many topics such as:

- Asthma management
- Diabetes management
- High blood pressure
- Cardiovascular Disease (CVD) management
- Chronic Obstructive Pulmonary Disease (COPD) management

You can also enroll in any of these programs by calling the Molina Health Education Department at 1 (866) 472-9483, between 9:30 a.m. and 6:30 p.m., Monday through Friday.

Molina's Health Management Department is committed to helping You stay well.

Find out if You are eligible to sign up for one of Our programs. Ask about other services We provide or request information to be mailed to You. The following are a list of programs and services Molina has to offer You.

Call toll-free 1 866-472-9483 (Monday through Friday, 9:30 a.m. – 6:30 p.m..

Motherhood Matters®

A Prenatal Care Program for Pregnant Women

Pregnancy is an important time in Your life. It can be even more important for Your baby. What You do during Your pregnancy can affect the health and well-being of Your baby – even after birth.

Motherhood Matters® is a program for pregnant women. This program will help women get the education and services they need for a healthy pregnancy. You will be mailed a pregnancy book that You can use as a reference throughout Your pregnancy. You will be able to talk with Our caring staff about any questions You may have during the pregnancy. They will teach You what You need to do. If any problems are found, a nurse will work closely with You and Your doctor to help You. Being a part of this program and following the guidelines will help You have a healthy pregnancy and a healthy baby.

Your Baby's Good Health Begins When You Are Pregnant

You Learn:

- Why visits to Your doctor are so important.
- How You can feel better during pregnancy.
- What foods are best to eat.

- What kinds of things to avoid.
- Why You should stay in touch with Molina's staff.
- When You need to call the doctor right away.

Other Benefits

- Health Education Materials – These include a pregnancy book.
- Referrals – To community resources available for pregnant women.

HEALTH EDUCATION

Molina's Health Education Department is committed to helping You stay well. Find out if You are eligible to sign up for one of Our programs. Call toll-free **1 (866) 472-9483** between 9:30 a.m. and 6:30 p.m. , Monday through Friday. Ask about other services We provide or request information to be mailed to You.

The following are a list of health education programs and services Molina has to offer You.

Smoking Cessation Program
This program offers smoking cessation services to all smokers interested in quitting the habit. The program is done over the telephone. You will also be mailed educational materials to help You stop the habit. A smoking cessation counselor will call You to offer support.

Weight Control Program
This program is for Members who need help controlling their weight. The weight control program is provided for Members 17 years and older. You will learn about healthy eating and exercise. This program is for Members who are ready to commit to losing weight. Once You have understood and agreed to the program participation criteria, You can enroll in the program.

Your Healthcare Quick Reference Guide

Department/Program	Type of help needed	Number to call/ Contact information
Molina Customer Support Center Department	If You have a problem with any of Molina's services, We want to help fix it. You can call Our Customer Support Center for help or to file a grievance or complaint Monday through Friday from 8:00 a.m. to 5:00 p.m. PT. When in doubt, call us first.	**Customer Support Center Toll Free:** 1 (888) 858-3492 **TTY line for the deaf or hard of hearing:** dial 711 for the National Relay Service
Health Management	To request any information on wellness including, but not limited to, nutrition, smoking cessation, weight management, stress management, child safety, asthma, and diabetes.	1(866) 472-9483 between 9:30 a.m. and 6:30 p.m.
Health Education	To request information on wellness, including smoking cessation and weight management.	1 (866) 472-9483 between 9:30 a.m. and 6:30 p.m.
Nurse Advice Line 24-Hour, 7 days a week	If You have questions or concerns about Your or Your family's health. The Nurse Advice Line is staffed by registered nurses.	1 (888) 275-8750 for Spanish 1 (866) 648-3537
Motherhood Matters®	Molina offers a special program called Motherhood Matters to Our pregnant members. This program provides important information about diet, exercise and other topics related to Your pregnancy.	1 (877) 665-4628
Secretary of the U.S. Department of Health and Human Services Office for Civil Rights	If You believe that We have not protected Your privacy and wish to complain, You may call to file a complaint (or grievance).	(800) 368-1019 **TDD for deaf or hard of hearing:** (800) 537-7697 **FAX:** (206)615-2297
Medicare	Medicare is health insurance offered by the federal government to most people who are 65 and older. Medicare helps pay for healthcare, but does not cover all medical expenses.	1 (800) MEDICARE **TTY for deaf or hard of hearing:** 1 (877) 486-2048 **www.Medicare.gov**
Washington State Office of the Insurance Commissioner	The Washington State Office of the Insurance Commissioner is responsible for regulating health care services plans.	(800) 562-6900 or 1 (360) 725-7080 **TDD 1 (360) 586-0241** Fax to 1 (360) 586-2018 www.insurance.wa.gov

The following language is to replace the existing language in MHW01012015 and/or MHW01012015B in the "Premium Payments and Termination for Non Payment" section of the Policy.

PREMIUM PAYMENTS AND TERMINATION FOR NONPAYMENT

As a result of the recent decision by the Health Benefit Exchange Board, effective September 24th, 2015 Healthplanfinder will no longer accept payments or invoice members for their premiums. Molina will assume the responsibility for Premium Payment Collection and Invoicing going forward.

Premium Notices/Termination for Non-Payment of Premiums. Your Premium payment obligations are as follows:

Your Premium payment for the upcoming coverage month is due no later than the 23rd day of the prior month. This is the "Due Date." Molina Healthcare will send you a bill in advance of the Due Date for the upcoming coverage month. If the full Premium payment is not received on or before the Due Date, Molina Healthcare will send a notice of non-receipt of Premium Payment (the "Late Notice") to the Subscriber's address of record.

21540 30th Dr. SE Suite 400
Bothell, WA 98021

MolinaHealthcare.com/Marketplace

Product offered by Molina Healthcare of Washington, Inc.,
a wholly owned subsidiary of Molina Healthcare, Inc.

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